This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure 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: 150115

Period:
From 07/01/2010
To 06/30/2011

Worksheet S
Parts I-III
Date/Time Prepared:
3/28/2012 1:32 pm

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically filed cost report — Date: 3/28/2012 Time: 1:32 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [ ] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [0] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN

10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 MEMORIAL HOSP & HEALTH CARE CTR for the cost reporting period beginning 07/01/2010 and ending 06/30/2011 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	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-424,056	196,160	0	0	1.00
2.00	Subprovider - IPF	0	4,642	0		0	2.00
3.00	Subprovider - IRF	0	11,405	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	3,506	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	FRENCH LICK (RHC) I	0		662		0	10.00
10.01	LOOGOOTEE (RHC) II	0		1,234		0	10.01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-404,503	198,056	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 150115

Period: From 07/01/2010 To 06/30/2011

Worksheet S-2 Part I Date/Time Prepared: 3/28/2012 1:31 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 800 WEST 9TH STREET	PO Box:			1.00
2.00	City: JASPER	State: IN	Zip Code: 47546	County: DUBOIS	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		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	MEMORIAL HOSP & HEALTH CARE CTR	150115	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	MEMORIAL HOSP & HCC (PSYCH)	15S115	99915	4	07/01/1985	N	P	O	4.00
5.00	Subprovider - IRF	MEMORIAL HOSP & HCC (REHAB)	15T115	99915	5	07/01/2005	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF						N	P	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF	MEMORIAL HOSP & HEALTH CARE CTR	155305	99915		08/04/1987	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	MEMORIAL HOSP & HEALTH CARE CTR	157222	99915		08/28/1991	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FRENCH LICK FAMILY MEDICINE	158507	99915		06/19/2009	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC 1	LOOGOOTEE FAMILY MEDICINE	158508	99915		12/14/2009	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC						N	N	N	16.00
17.00	Hospital-Based (CMHC) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2010	06/30/2011	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of State Medicaid paid days	Out-of State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	1,155	436	0	0	1,475	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	28	0	25.00

		1.00	
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	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.	2	27.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150115	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 3/28/2012 1:31 pm

		1.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0	35.00

		Beginning: 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.				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)	N	0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00

		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	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	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: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part I Date/Time Prepared: 3/28/2012 1:31 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	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	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.	Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N	N	0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.	N	80.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part I Date/Time Prepared: 3/28/2012 1:31 pm

		1.00	
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	N	86.00

		V	XIX	
		1.00	2.00	
	Title V or XIX Inpatient Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			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)			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.					109.00

		1.00	2.00	
	Miscellaneous Cost Reporting Information			
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.	N	N	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.	250,000	7,500,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	N	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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150115	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 3/28/2012 1:31 pm

		1.00	2.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	
		1.00	2.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)			
155.00	Hospital	N	N	155.00
156.00	Subprovider - IPF	N	N	156.00
157.00	Subprovider - IRF	N	N	157.00
158.00	SUBPROVIDER	N	N	158.00
159.00	SNF	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	160.00
161.00	CMHC		N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	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: 150115	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 3/28/2012 1:31 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.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Description	Part A Y/N	Part A 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	12/13/2011		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part II Date/Time Prepared: 3/28/2012 1:31 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150115	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 3/28/2012 1:31 pm

		Part B		
		Y/N	Date	
		3.00	4.00	
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	12/13/2011	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours		
		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	85	31,025	0.00		1.00
2.00	HMO						2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		85	31,025	0.00		7.00
8.00	INTENSIVE CARE UNIT	31.00	26	9,490	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)		111	40,515	0.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	40.00	9	3,285			16.00
17.00	SUBPROVIDER - IRF	41.00	8	2,920			17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	20	7,300			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	FRENCH LICK (RHC)	88.00					26.00
26.01	LOOGOOTEE (RHC)	88.01					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00	Total (sum of lines 14-26)		148				27.00
28.00	Observation Bed Days						28.00
28.01	SUBPROVIDER - IPF	40.00					28.01
28.02	SUBPROVIDER - IRF	41.00					28.02
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I Date/Time Prepared: 3/28/2012 1:31 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	7,153	679	14,190		1.00
2.00	HMO		713	1,794			2.00
3.00	HMO IPF		0	0			3.00
4.00	HMO IRF		38	28			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	7,153	679	14,190		7.00
8.00	INTENSIVE CARE UNIT	0	3,293	141	5,286		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		335	1,766		13.00
14.00	Total (see instructions)	0	10,446	1,155	21,242		14.00
15.00	CAH visits	0	0	0	0		15.00
16.00	SUBPROVIDER - IPF	0	925	407	2,144		16.00
17.00	SUBPROVIDER - IRF	0	1,149	37	1,632		17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	4,108	59	5,059		19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	4,916	0	8,760		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	FRENCH LICK (RHC)	0	873	0	3,317		26.00
26.01	LOOGOOTEE (RHC)	0	2,082	0	7,045		26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00	Total (sum of lines 14-26)						27.00
28.00	Observation Bed Days	0		0	1,193		28.00
28.01	SUBPROVIDER - IPF				28		28.01
28.02	SUBPROVIDER - IRF				0		28.02
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)			117	248		32.00
33.00	LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I Date/Time Prepared: 3/28/2012 1:31 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	2,877	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	1,003.08	0.00	0	2,877	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	15.51	0.00	0	115	16.00
17.00	SUBPROVIDER - IRF	0.00	12.23	0.00	0	88	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00	25.37	0.00			19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00	14.14	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	FRENCH LICK (RHC)	0.00	3.30	0.00			26.00
26.01	LOOGOOTEE (RHC)	0.00	5.59	0.00			26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00	Total (sum of lines 14-26)	0.00	1,079.22	0.00			27.00
28.00	Observation Bed Days						28.00
28.01	SUBPROVIDER - IPF						28.01
28.02	SUBPROVIDER - IRF						28.02
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I Date/Time Prepared: 3/28/2012 1:31 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)	594	6,063		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)	594	6,063		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF	74	365		16.00
17.00	SUBPROVIDER - IRF	2	113		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	FRENCH LICK (RHC)				26.00
26.01	LOOGOOTEE (RHC)				26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
28.01	SUBPROVIDER - IPF				28.01
28.02	SUBPROVIDER - IRF				28.02
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days - IRF				31.00
32.00	Labor & delivery days (see instructions)				32.00
33.00	LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part II Date/Time Prepared: 3/28/2012 1:31 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
		1.00	2.00	3.00	4.00	5.00	
	PART II - WAGE DATA						
	SALARIES						
1.00	Total salaries (see instructions)	200.00	62,051,809	0	62,051,809	2,244,781.00	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	2.00
3.00	Non-physician anesthetist Part B		1,531,382	0	1,531,382	14,939.00	3.00
4.00	Physician-Part A		0	0	0	0.00	4.00
4.01	Physicians - Part A - direct teaching		0	0	0	0.00	4.01
5.00	Physician-Part B		11,664,503	0	11,664,503	76,182.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	7.00
7.01	Contracted interns and residents (in approved programs)		0	0	0	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	8.00
9.00	SNF	44.00	1,123,926	0	1,123,926	52,770.00	9.00
10.00	Excluded area salaries (see instructions)		15,448,281	0	15,448,281	466,494.00	10.00
	OTHER WAGES & RELATED COSTS						
11.00	Contract labor (see instructions)		97,648	0	97,648	1,355.00	11.00
12.00	Management and administrative services		0	0	0	0.00	12.00
13.00	Contract labor: physician-Part A		1,250,647	0	1,250,647	5,294.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	14.00
15.00	Home office: physician Part A		0	0	0	0.00	15.00
16.00	Teaching physician salaries (see instructions)		0	0	0	0.00	16.00
	WAGE-RELATED COSTS						
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		7,014,362	0	7,014,362		17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25		0	0	0		18.00
19.00	Excluded areas		3,600,684	0	3,600,684		19.00
20.00	Non-physician anesthetist Part A		0	0	0		20.00
21.00	Non-physician anesthetist Part B		332,727	0	332,727		21.00
22.00	Physician Part A		0	0	0		22.00
23.00	Physician Part B		2,534,375	0	2,534,375		23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0		24.00
25.00	Interns & residents (in an approved program)		0	0	0		25.00
	OVERHEAD COSTS - DIRECT SALARIES						
26.00	Employee Benefits	4.00	2,028,329	0	2,028,329	18,042.00	26.00
27.00	Administrative & General	5.00	6,301,385	0	6,301,385	289,941.00	27.00
28.00	Administrative & General under contract (see inst.)		720,337	0	720,337	2,515.00	28.00
29.00	Maintenance & Repairs	6.00	1,472,117	0	1,472,117	67,152.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	30.00
31.00	Laundry & Linen Service	8.00	222,402	0	222,402	20,309.00	31.00
32.00	Housekeeping	9.00	953,606	0	953,606	85,433.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	33.00
34.00	Dietary	10.00	982,963	-670,002	312,961	22,386.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	35.00
36.00	Cafeteria	11.00	0	670,002	670,002	47,924.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	37.00
38.00	Nursing Administration	13.00	718,431	0	718,431	24,313.00	38.00
39.00	Central Services and Supply	14.00	214,818	0	214,818	16,822.00	39.00
40.00	Pharmacy	15.00	1,243,750	0	1,243,750	38,045.00	40.00
41.00	Medical Records & Medical Records Library	16.00	778,397	0	778,397	45,756.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part II Date/Time Prepared: 3/28/2012 1:31 pm

		Average Hourly Wage (col. 4 ÷ col. 5)		
		6.00		
	PART II - WAGE DATA			
	SALARIES			
1.00	Total salaries (see instructions)	27.64		1.00
2.00	Non-physician anesthetist Part A	0.00		2.00
3.00	Non-physician anesthetist Part B	102.51		3.00
4.00	Physician-Part A	0.00		4.00
4.01	Physicians - Part A - direct teaching	0.00		4.01
5.00	Physician-Part B	153.11		5.00
6.00	Non-physician-Part B	0.00		6.00
7.00	Interns & residents (in an approved program)	0.00		7.00
7.01	Contracted interns and residents (in approved programs)	0.00		7.01
8.00	Home office personnel	0.00		8.00
9.00	SNF	21.30		9.00
10.00	Excluded area salaries (see instructions)	33.12		10.00
	OTHER WAGES & RELATED COSTS			
11.00	Contract labor (see instructions)	72.06		11.00
12.00	Management and administrative services	0.00		12.00
13.00	Contract labor: physician-Part A	236.24		13.00
14.00	Home office salaries & wage-related costs	0.00		14.00
15.00	Home office: physician Part A	0.00		15.00
16.00	Teaching physician salaries (see instructions)	0.00		16.00
	WAGE-RELATED COSTS			
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24			17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25			18.00
19.00	Excluded areas			19.00
20.00	Non-physician anesthetist Part A			20.00
21.00	Non-physician anesthetist Part B			21.00
22.00	Physician Part A			22.00
23.00	Physician Part B			23.00
24.00	Wage-related costs (RHC/FQHC)			24.00
25.00	Interns & residents (in an approved program)			25.00
	OVERHEAD COSTS - DIRECT SALARIES			
26.00	Employee Benefits	112.42		26.00
27.00	Administrative & General	21.73		27.00
28.00	Administrative & General under contract (see inst.)	286.42		28.00
29.00	Maintenance & Repairs	21.92		29.00
30.00	Operation of Plant	0.00		30.00
31.00	Laundry & Linen Service	10.95		31.00
32.00	Housekeeping	11.16		32.00
33.00	Housekeeping under contract (see instructions)	0.00		33.00
34.00	Dietary	13.98		34.00
35.00	Dietary under contract (see instructions)	0.00		35.00
36.00	Cafeteria	13.98		36.00
37.00	Maintenance of Personnel	0.00		37.00
38.00	Nursing Administration	29.55		38.00
39.00	Central Services and Supply	12.77		39.00
40.00	Pharmacy	32.69		40.00
41.00	Medical Records & Medical Records Library	17.01		41.00
42.00	Social Service	0.00		42.00
43.00	Other General Service	0.00		43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part III Date/Time Prepared: 3/28/2012 1:31 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
		1.00	2.00	3.00	4.00	5.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY						
1.00	Net salaries (see instructions)		49,576,261	0	49,576,261	2,156,175.00	1.00
2.00	Excluded area salaries (see instructions)		16,572,207	0	16,572,207	519,264.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		33,004,054	0	33,004,054	1,636,911.00	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,348,295	0	1,348,295	6,649.00	4.00
5.00	Subtotal wage-related costs (see inst.)		7,014,362	0	7,014,362	0.00	5.00
6.00	Total (sum of lines 3 thru 5)		41,366,711	0	41,366,711	1,643,560.00	6.00
7.00	Total overhead cost (see instructions)		15,636,535	0	15,636,535	678,638.00	7.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150115

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-3
Part III
Date/Time Prepared:
3/28/2012 1:31 pm

		Average Hourly Wage (col. 4 ÷ col. 5)		
		6.00		
	PART III - HOSPITAL WAGE INDEX SUMMARY			
1.00	Net salaries (see instructions)	22.99		1.00
2.00	Excluded area salaries (see instructions)	31.91		2.00
3.00	Subtotal salaries (line 1 minus line 2)	20.16		3.00
4.00	Subtotal other wages & related costs (see inst.)	202.78		4.00
5.00	Subtotal wage-related costs (see inst.)	21.25		5.00
6.00	Total (sum of lines 3 thru 5)	25.17		6.00
7.00	Total overhead cost (see instructions)	23.04		7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 150115	Period: From 07/01/2010 To 06/30/2011	Worksheet S-3 Part IV Date/Time Prepared: 3/28/2012 1:31 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	176,222	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	999,540	3.00
4.00	Prior Year Pension Service Cost	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,444,993	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	28,004	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	102,619	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	139,594	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,016,291	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	24,471	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	29,256	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,960,990	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part V Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00		0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 150115
Component CCN: 157222

Period: From 07/01/2010 To 06/30/2011

Worksheet S-4
Date/Time Prepared: 3/28/2012 1:31 pm

		Home Health Agency I	PPS
		1.00	
0.00	County	DUBOIS	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	3,161	419	1,278	4,858	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	309.00	41.00	125.00	475.00	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)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		1.01	0.00	1.01	4.00
5.00	Other Administrative Personnel		2.88	0.00	2.88	5.00
6.00	Direct Nursing Service		4.90	0.00	4.90	6.00
7.00	Nursing Supervisor		1.02	0.00	1.02	7.00
8.00	Physical Therapy Service		1.25	0.00	1.25	8.00
9.00	Physical Therapy Supervisor		0.21	0.00	0.21	9.00
10.00	Occupational Therapy Service		0.48	0.00	0.48	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.03	0.00	0.03	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.01	0.00	0.01	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		2.34	0.00	2.34	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99915			20.00

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,851	78	64	54	2,047	21.00
22.00	Skilled Nursing Visit Charges	321,140	13,159	12,413	9,425	356,137	22.00
23.00	Physical Therapy Visits	1,297	0	28	43	1,368	23.00
24.00	Physical Therapy Visit Charges	233,274	0	5,076	7,756	246,106	24.00
25.00	Occupational Therapy Visits	387	0	4	18	409	25.00
26.00	Occupational Therapy Visit Charges	69,464	0	728	3,226	73,418	26.00
27.00	Speech Pathology Visits	30	0	0	1	31	27.00
28.00	Speech Pathology Visit Charges	5,370	0	0	182	5,552	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	1,019	0	5	37	1,061	31.00
32.00	Home Health Aide Visit Charges	79,709	0	387	2,887	82,983	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,584	78	101	153	4,916	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)	708,957	13,159	18,604	23,476	764,196	35.00
36.00	Total Number of Episodes (standard/non outlier)	271		36	8	315	36.00
37.00	Total Number of Outlier Episodes		2		0	2	37.00
38.00	Total Non-Routine Medical Supply Charges	17,156	1,019	736	507	19,418	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 150115	Period: From 07/01/2010 To 06/30/2011	Worksheet S-7 Date/Time Prepared: 3/28/2012 1:31 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	92	0	92	5.00
6.00		RVL	253	0	253	6.00
7.00		RHX	8	0	8	7.00
8.00		RHL	21	0	21	8.00
9.00		RMX	295	0	295	9.00
10.00		RML	336	0	336	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	9	0	9	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	68	0	68	15.00
16.00		RVB	195	0	195	16.00
17.00		RVA	493	0	493	17.00
18.00		RHC	491	0	491	18.00
19.00		RHB	309	0	309	19.00
20.00		RHA	606	0	606	20.00
21.00		RMC	220	0	220	21.00
22.00		RMB	130	0	130	22.00
23.00		RMA	310	0	310	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	20	0	20	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	7	0	7	30.00
31.00		HD2	9	0	9	31.00
32.00		HD1	3	0	3	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	23	0	23	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	5	0	5	36.00
37.00		LE2	6	0	6	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	14	0	14	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	11	0	11	43.00
44.00		LB1	2	0	2	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	36	0	36	48.00
49.00		CC2	4	0	4	49.00
50.00		CC1	31	0	31	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	23	0	23	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	12	0	12	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	58	0	58	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	6	0	6	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 150115	Period: From 07/01/2010 To 06/30/2011	Worksheet S-7 Date/Time Prepared: 3/28/2012 1:31 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	2	0	2	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		4,108	0	4,108	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	15	15	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	1,151,340			207.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 150115
Component CCN: 158507

Period: From 07/01/2010 To 06/30/2011

Worksheet S-8

Date/Time Prepared: 3/28/2012 1:31 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	522 SOUTH MAPLE STREET	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	FRENCH LICK	IN	47432	2.00

		1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday			
		from	to	from	to		
		1.00	2.00	3.00	4.00		
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00		11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number			14.00

		Y/N	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)		0	0	0	15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 150115 Component CCN: 158507	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 3/28/2012 1:31 pm
		Rural Health Clinic (RHC) I	Cost

		County					
		4.00					
2.00	City, State, Zip Code, County	ORANGE					2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	06:00	15:00	08:00	12:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 150115 Component CCN: 158507	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 3/28/2012 1:31 pm
		Rural Health Clinic (RHC) I	Cost

		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00	06:00	15:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 150115 Component CCN: 158507	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 3/28/2012 1:31 pm
		Rural Health Clinic (RHC) I	Cost

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

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 150115
Component CCN: 158508

Period: From 07/01/2010 To 06/30/2011

Worksheet S-8

Date/Time Prepared: 3/28/2012 1:31 pm

		Rural Health Clinic (RHC) II	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	105 COOPER STREET	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	LOOGOOTEE	IN	47553	2.00

			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday			
		from	to	from	to		
		1.00	2.00	3.00	4.00		
	Facility hours of operations (1)						
11.00	Clinic			08:00	18:00		11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number			14.00

		Y/N	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)		0	0	0	15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 150115 Component CCN: 158508	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 3/28/2012 1:31 pm
		Rural Health Clinic (RHC) II	Cost

		County					
		4.00					
2.00	City, State, Zip Code, County	MARTIN					2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	18:00	08:00	18:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 150115 Component CCN: 158508	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 3/28/2012 1:31 pm
		Rural Health Clinic (RHC) II	Cost

		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	18:00	08:00	12:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 150115 Component CCN: 158508	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 3/28/2012 1:31 pm
		Rural Health Clinic (RHC) II	Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150115	Period: From 07/01/2010 To 06/30/2011	Worksheet S-10 Date/Time Prepared: 3/28/2012 1:31 pm

		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)	0.416492	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,158,189	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	16,827,885	6.00
7.00	Medicaid cost (line 1 times line 6)	7,008,679	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)	2,850,490	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)	2,850,490	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	4,675,573	0	4,675,573	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,947,339	0	1,947,339	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,947,339	0	1,947,339	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	7,373,802	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	383,150	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	6,990,652	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	2,911,551	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	4,858,890	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,709,380	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A | Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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	CAP REL COSTS-BLDG & FIXT		6,541,292	6,541,292	0	6,541,292	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		5,905,840	5,905,840	0	5,905,840	2.00
4.00	EMPLOYEE BENEFITS	2,028,329	13,825,597	15,853,926	0	15,853,926	4.00
5.00	ADMINISTRATIVE & GENERAL	6,301,385	15,708,378	22,009,763	0	22,009,763	5.00
6.00	MAINTENANCE & REPAIRS	1,472,117	4,835,450	6,307,567	0	6,307,567	6.00
8.00	LAUNDRY & LINEN SERVICE	222,402	86,371	308,773	0	308,773	8.00
9.00	HOUSEKEEPING	953,606	194,540	1,148,146	0	1,148,146	9.00
10.00	DIETARY	982,963	627,237	1,610,200	-1,105,332	504,868	10.00
11.00	CAFETERIA	0	0	0	1,097,536	1,097,536	11.00
13.00	NURSING ADMINISTRATION	718,431	64,750	783,181	0	783,181	13.00
14.00	CENTRAL SERVICES & SUPPLY	214,818	280,324	495,142	-203,476	291,666	14.00
15.00	PHARMACY	1,243,750	8,144,036	9,387,786	0	9,387,786	15.00
16.00	MEDICAL RECORDS & LIBRARY	778,397	80,255	858,652	0	858,652	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,971,431	502,558	6,473,989	-618,836	5,855,153	30.00
31.00	INTENSIVE CARE UNIT	2,321,327	95,384	2,416,711	-8,406	2,408,305	31.00
40.00	SUBPROVIDER - IPF	1,036,036	52,522	1,088,558	0	1,088,558	40.00
41.00	SUBPROVIDER - IRF	604,434	135,555	739,989	0	739,989	41.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	1,123,926	53,139	1,177,065	-13,721	1,163,344	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	3,273,525	3,139,726	6,413,251	-2,326,812	4,086,439	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	417,599	417,599	52.00
53.00	ANESTHESIOLOGY	2,967,550	343,173	3,310,723	-128,739	3,181,984	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,864,029	728,327	2,592,356	-68,660	2,523,696	54.00
56.00	RADIOISOTOPE	185,437	459,505	644,942	0	644,942	56.00
60.00	LABORATORY	2,188,840	3,493,274	5,682,114	0	5,682,114	60.00
65.00	RESPIRATORY THERAPY	1,035,019	339,185	1,374,204	-99,675	1,274,529	65.00
66.00	PHYSICAL THERAPY	1,551,359	292,858	1,844,217	-46,973	1,797,244	66.00
69.00	ELECTROCARDIOLOGY	1,468,124	4,302,557	5,770,681	-2,422,058	3,348,623	69.00
69.01	PULMONARY	0	0	0	60,760	60,760	69.01
69.02	CARDIOPULMONARY	99,141	4,163	103,304	0	103,304	69.02
69.03	SLEEP LAB	125,212	83,345	208,557	0	208,557	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,252,293	5,252,293	-2,366,162	2,886,131	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,849,232	7,849,232	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	175,918	72,530	248,448	0	248,448	88.00
88.01	LOOGOOTEE (RHC)	394,880	67,074	461,954	0	461,954	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	208,523	261,107	469,630	-6,979	462,651	90.00
90.01	IMED	415,191	142,208	557,399	-5,380	552,019	90.01
90.02	ONCOLOGY	989,001	968,661	1,957,662	0	1,957,662	90.02
91.00	EMERGENCY	5,328,897	504,469	5,833,366	0	5,833,366	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	1,410,846	160,082	1,570,928	0	1,570,928	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	HOME HEALTH AGENCY	730,509	151,647	882,156	0	882,156	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	97,711	12,756	110,467	0	110,467	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	50,483,064	77,912,168	128,395,232	3,918	128,399,150	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	9,591,889	3,511,725	13,103,614	-3,918	13,099,696	192.00
192.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	505,522	31,872	537,394	0	537,394	192.01
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	MEMORIAL HOSPITAL FOUNDATION	143,040	2,915	145,955	0	145,955	194.02
194.03	MKT/PHY SERVICES	897,868	980,357	1,878,225	0	1,878,225	194.03
194.04	COMMUNITY EDUCATION	273,018	118,190	391,208	0	391,208	194.04
194.06	MAB	0	0	0	0	0	194.06
194.08	PUBLIC RELATIONS	157,408	406,936	564,344	0	564,344	194.08
194.09	UNUSED SPACE	0	0	0	0	0	194.09
200.00	TOTAL (SUM OF LINES 118-199)	62,051,809	82,964,163	145,015,972	0	145,015,972	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A | Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	-1,500,447	5,040,845		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,905,840		2.00
4.00	EMPLOYEE BENEFITS	-925,196	14,928,730		4.00
5.00	ADMINISTRATIVE & GENERAL	-7,684,862	14,324,901		5.00
6.00	MAINTENANCE & REPAIRS	-2,642	6,304,925		6.00
8.00	LAUNDRY & LINEN SERVICE	-737	308,036		8.00
9.00	HOUSEKEEPING	-637	1,147,509		9.00
10.00	DIETARY	-55,101	449,767		10.00
11.00	CAFETERIA	-441,269	656,267		11.00
13.00	NURSING ADMINISTRATION	-4,121	779,060		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	291,666		14.00
15.00	PHARMACY	-228,330	9,159,456		15.00
16.00	MEDICAL RECORDS & LIBRARY	-22,435	836,217		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	5,855,153		30.00
31.00	INTENSIVE CARE UNIT	0	2,408,305		31.00
40.00	SUBPROVIDER - IPF	-29,815	1,058,743		40.00
41.00	SUBPROVIDER - IRF	-88,573	651,416		41.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	-4,734	1,158,610		44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-75	4,086,364		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	417,599		52.00
53.00	ANESTHESIOLOGY	-2,968,288	213,696		53.00
54.00	RADIOLOGY-DIAGNOSTIC	-75	2,523,621		54.00
56.00	RADIOISOTOPE	0	644,942		56.00
60.00	LABORATORY	-151,803	5,530,311		60.00
65.00	RESPIRATORY THERAPY	-13,493	1,261,036		65.00
66.00	PHYSICAL THERAPY	-8,766	1,788,478		66.00
69.00	ELECTROCARDIOLOGY	-821,834	2,526,789		69.00
69.01	PULMONARY	0	60,760		69.01
69.02	CARDIOPULMONARY	0	103,304		69.02
69.03	SLEEP LAB	-17,868	190,689		69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,886,131		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	7,849,232		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	FRENCH LICK (RHC)	-15,820	232,628		88.00
88.01	LOOGOOTEE (RHC)	-43,254	418,700		88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	CLINIC	-13,200	449,451		90.00
90.01	IMED	-211,880	340,139		90.01
90.02	ONCOLOGY	-59,732	1,897,930		90.02
91.00	EMERGENCY	-2,648,268	3,185,098		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	-5,481	1,565,447		95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
101.00	HOME HEALTH AGENCY	-175	881,981		101.00
	SPECIAL PURPOSE COST CENTERS				
116.00	HOSPICE	0	110,467		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-17,968,911	110,430,239		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	13,099,696		192.00
192.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	537,394		192.01
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.02	MEMORIAL HOSPITAL FOUNDATION	0	145,955		194.02
194.03	MKT/PHY SERVICES	0	1,878,225		194.03
194.04	COMMUNITY EDUCATION	0	391,208		194.04
194.06	MAB	0	0		194.06
194.08	PUBLIC RELATIONS	0	564,344		194.08
194.09	UNUSED SPACE	0	0		194.09
200.00	TOTAL (SUM OF LINES 118-199)	-17,968,911	127,047,061		200.00

RECLASSIFICATIONS | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-6 | Date/Time Prepared: 3/28/2012 1:31 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - PULMONARY FUNCTION TESTING				
1.00	PULMONARY	69.01	60,760	0	1.00
	TOTALS		60,760	0	
	B - LABOR AND DELIVERY				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	355,441	62,158	1.00
	TOTALS		355,441	62,158	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	670,002	427,534	1.00
	TOTALS		670,002	427,534	
	D - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	7,849,232	1.00
	TOTALS		0	7,849,232	
	E - BILLABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,483,070	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	TOTALS		0	5,483,070	
500.00	Grand Total: Increases		1,086,203	13,821,994	500.00

RECLASSIFICATIONS | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-6 | Date/Time Prepared: 3/28/2012 1:31 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PULMONARY FUNCTION TESTING						
1.00	RESPIRATORY THERAPY	65.00	60,760	0	0		1.00
	TOTALS		60,760	0			
	B - LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	355,441	62,158	0		1.00
	TOTALS		355,441	62,158			
	C - CAFETERIA						
1.00	DIETARY	10.00	670,002	427,534	0		1.00
	TOTALS		670,002	427,534			
	D - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,849,232	0		1.00
	TOTALS		0	7,849,232			
	E - BILLABLE SUPPLIES						
1.00	DIETARY	10.00	0	7,796	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	203,476	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	201,237	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	8,406	0		4.00
5.00	SKILLED NURSING FACILITY	44.00	0	13,721	0		5.00
6.00	OPERATING ROOM	50.00	0	2,326,812	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	128,739	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	68,660	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	38,915	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	46,973	0		10.00
11.00	ELECTROCARDIOLOGY	69.00	0	2,422,058	0		11.00
12.00	CLINIC	90.00	0	6,979	0		12.00
13.00	IMED	90.01	0	5,380	0		13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,918	0		14.00
	TOTALS		0	5,483,070			
500.00	Grand Total: Decreases		1,086,203	13,821,994			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III Date/Time Prepared: 3/28/2012 1:31 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,545,814	361,841	0	361,841	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	103,172,482	1,302,143	0	1,302,143	0	3.00
4.00	Building Improvements	0	381,931	0	381,931	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	59,850,901	2,557,876	0	2,557,876	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	168,569,197	4,603,791	0	4,603,791	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	168,569,197	4,603,791	0	4,603,791	0	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	CAP REL COSTS-BLDG & FIXT	3,954,510	0	2,442,812	143,970	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,905,840	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	9,860,350	0	2,442,812	143,970	0	3.00

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	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	CAP REL COSTS-BLDG & FIXT	110,764,217	0	110,764,217	0.639616	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	62,408,771	0	62,408,771	0.360384	0	2.00
3.00	Total (sum of lines 1-2)	173,172,988	0	173,172,988	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III Date/Time Prepared: 3/28/2012 1:31 pm

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	5,907,655	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	104,474,625	0	3.00
4.00	Building Improvements	381,931	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	62,408,777	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	173,172,988	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	173,172,988	0	10.00

	Cost Center Description	SUMMARY OF CAPITAL		
		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	CAP REL COSTS-BLDG & FIXT	0	6,541,292	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,905,840	2.00
3.00	Total (sum of lines 1-2)	0	12,447,132	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,929,773	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,905,840	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	9,835,613	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	967,102	143,970	0	0	5,040,845	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	5,905,840	2.00
3.00	Total (sum of lines 1-2)	967,102	143,970	0	0	10,946,685	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 3/28/2012 1:31 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	4.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)		0		0.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-8,381	ADMINISTRATIVE & GENERAL	5.00	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	-6,601,380			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-1,601	ADMINISTRATIVE & GENERAL	5.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00	Laundry and linen service	B	-737	LAUNDRY & LINEN SERVICE	8.00	13.00
14.00	Cafeteria-employees and guests	B	-441,269	CAFETERIA	11.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients	B	-228,330	PHARMACY	15.00	17.00
18.00	Sale of medical records and abstracts	B	-22,435	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines	B	-5,792	ADMINISTRATIVE & GENERAL	5.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	TELEPHONE DEPRECIATION	A	-24,371	CAP REL COSTS-BLDG & FIXT	1.00	33.00
33.01	MAINTENANCE	B	-1,865	MAINTENANCE & REPAIRS	6.00	33.01
33.02	MISCELLANEOUS REVENUE	B	-539	ADMINISTRATIVE & GENERAL	5.00	33.02
33.03	ADVERTISING - BENEFITS	A	-18,860	EMPLOYEE BENEFITS	4.00	33.03
33.04	ADVERTISING - ADMIN & GENERAL	A	-63	ADMINISTRATIVE & GENERAL	5.00	33.04
33.05	ADVERTISING - ONCOLOGY	A	-132	ONCOLOGY	90.02	33.05
33.06	ADVERTISING - FRENCH LICK RHC	A	-1,271	FRENCH LICK (RHC)	88.00	33.06
33.07	ADVERTISING - LOOGOOTEE RHC	A	-1,082	LOOGOOTEE (RHC)	88.01	33.07
33.08	ADVERTISING - AMBULANCE	A	-4,081	AMBULANCE SERVICES	95.00	33.08
33.09	CLINICAL ENGINEERING	B	-777	MAINTENANCE & REPAIRS	6.00	33.09
33.10	MISCELLANEOUS - DIETARY	B	-331	DIETARY	10.00	33.10
33.11	MISCELLANEOUS - LAB	B	-1,803	LABORATORY	60.00	33.11
33.12	MISCELLANEOUS - FINANCE	B	-58,770	ADMINISTRATIVE & GENERAL	5.00	33.12
33.13	MISCELLANEOUS - AMBULANCE	B	-1,400	AMBULANCE SERVICES	95.00	33.13
33.14	ACCOUNTS PAYABLE DICSOUNT	B	-38,783	ADMINISTRATIVE & GENERAL	5.00	33.14
33.15	MISCELLANEOUS - SURGERY	B	-75	OPERATING ROOM	50.00	33.15
33.16	MISCELLANEOUS - HHA	B	-175	HOME HEALTH AGENCY	101.00	33.16
33.17	MISCELLANEOUS - SLEEP LAB	B	-368	SLEEP LAB	69.03	33.17
33.18	MISCELLANEOUS - PHYSICAL THERAPY	B	-902	PHYSICAL THERAPY	66.00	33.18
33.19	MISCELLANEOUS - CLINCAL	B	-4,121	NURSING ADMINISTRATION	13.00	33.19
33.20	MISCELLANEOUS - FRENCH LICK RHC	B	-14,549	FRENCH LICK (RHC)	88.00	33.20
33.21	MISCELLANEOUS - LOOGOOTEE RHC	B	-42,172	LOOGOOTEE (RHC)	88.01	33.21

ADJUSTMENTS TO EXPENSES | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 3/28/2012 1:31 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	4.00	
33.22	BAD DEBT EXPENSE ADJUSTMENT	A	-7,373,802	ADMINISTRATIVE & GENERAL	5.00	33.22
33.23	MISCELLANEOUS - RADIOLOGY	B	-75	RADIOLOGY-DIAGNOSTIC	54.00	33.23
33.24	MISCELLANEOUS - ONCOLOGY	B	-140	ONCOLOGY	90.02	33.24
33.25	MISCELLANEOUS - HOUSEKEEPING	B	-637	HOUSEKEEPING	9.00	33.25
33.26	CRNA EXPENSE	A	-1,531,382	ANESTHESIOLOGY	53.00	33.26
33.27	MISC. PROC. CENTER	B	-2,080	ADMINISTRATIVE & GENERAL	5.00	33.27
33.28	AHA LIVES - 1993	A	-366	CAP REL COSTS-BLDG & FIXT	1.00	33.28
33.29	AHA IHA LOBBYING DUES	A	-3,534	ADMINISTRATIVE & GENERAL	5.00	33.29
33.30	INTEREST	B	-1,475,710	CAP REL COSTS-BLDG & FIXT	1.00	33.30
33.31	DIETARY SUPPLEMENTS	B	-54,770	DIETARY	10.00	33.31
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-17,968,911			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	Wkst. A-7 Ref. 5.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0		1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0		2.00
3.00	Investment income - other (chapter 2)	0		3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0		4.00
5.00	Refunds and rebates of expenses (chapter 8)	0		5.00
6.00	Rental of provider space by suppliers (chapter 8)	0		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0		7.00
8.00	Television and radio service (chapter 21)	0		8.00
9.00	Parking lot (chapter 21)	0		9.00
10.00	Provider-based physician adjustment	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0		11.00
12.00	Related organization transactions (chapter 10)	0		12.00
13.00	Laundry and linen service	0		13.00
14.00	Cafeteria-employees and guests	0		14.00
15.00	Rental of quarters to employee and others	0		15.00
16.00	Sale of medical and surgical supplies to other than patients	0		16.00
17.00	Sale of drugs to other than patients	0		17.00
18.00	Sale of medical records and abstracts	0		18.00
19.00	Nursing school (tuition, fees, books, etc.)	0		19.00
20.00	Vending machines	0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	0		26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	0		27.00
28.00	Non-physician Anesthetist			28.00
29.00	Physicians' assistant	0		29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0		32.00
33.00	TELEPHONE DEPRECIATION	9		33.00
33.01	MAINTENANCE	0		33.01
33.02	MISCELLANEOUS REVENUE	0		33.02
33.03	ADVERTISING - BENEFITS	0		33.03
33.04	ADVERTISING - ADMIN & GENERAL	0		33.04
33.05	ADVERTISING - ONCOLOGY	0		33.05
33.06	ADVERTISING - FRENCH LICK RHC	0		33.06
33.07	ADVERTISING - LOOGOOTEE RHC	0		33.07
33.08	ADVERTISING - AMBULANCE	0		33.08
33.09	CLINICAL ENGINEERING	0		33.09
33.10	MISCELLANEOUS - DIETARY	0		33.10
33.11	MISCELLANEOUS - LAB	0		33.11
33.12	MISCELLANEOUS - FINANCE	0		33.12
33.13	MISCELLANEOUS - AMBULANCE	0		33.13
33.14	ACCOUNTS PAYABLE DICSOUNT	0		33.14
33.15	MISCELLANEOUS - SURGERY	0		33.15
33.16	MISCELLANEOUS - HHA	0		33.16
33.17	MISCELLANEOUS - SLEEP LAB	0		33.17
33.18	MISCELLANEOUS - PHYSICAL THERAPY	0		33.18
33.19	MISCELLANEOUS - CLINCAL	0		33.19
33.20	MISCELLANEOUS - FRENCH LICK RHC	0		33.20
33.21	MISCELLANEOUS - LOOGOOTEE RHC	0		33.21
33.22	BAD DEBT EXPENSE ADJUSTMENT	0		33.22
33.23	MISCELLANEOUS - RADIOLOGY	0		33.23
33.24	MISCELLANEOUS - ONCOLOGY	0		33.24
33.25	MISCELLANEOUS - HOUSEKEEPING	0		33.25
33.26	CRNA EXPENSE	0		33.26
33.27	MISC. PROC. CENTER	0		33.27

ADJUSTMENTS TO EXPENSES

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	Cost Center Description	Wkst. A-7 Ref. 5.00	
33.28	AHA LIVES - 1993	9	33.28
33.29	AHA IHA LOBBYING DUES	0	33.29
33.30	INTEREST	11	33.30
33.31	DIETARY SUPPLEMENTS	0	33.31
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: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 3/28/2012 1:31 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		53.00	ANESTHESIOLOGY SALARY	1,322,248	1,322,248	1.00
2.00		91.00	EMERGENCY SALARY	2,489,568	2,489,568	2.00
3.00		90.01	IMED SALARY	196,525	196,525	3.00
4.00		90.02	ONCOLOGY SALARY	59,460	59,460	4.00
5.00		91.00	EMERGENCY - CONTRACTED	158,700	158,700	5.00
6.00		90.01	IMED - CONTRACTED	15,355	15,355	6.00
7.00		40.00	PSYCH - CONTRACTED	29,815	29,815	7.00
8.00		41.00	REHAB - CONTRACTED	119,950	28,287	8.00
9.00		44.00	SNF - CONTRACTED	7,200	0	9.00
10.00		53.00	ANESTHESIOLOGY - CONTRACTED	114,693	114,658	10.00
11.00		60.00	LAB - CONTRACTED	150,000	150,000	11.00
12.00		65.00	RT - CONTRACTED	22,468	0	12.00
13.00		66.00	PT - CONTRACTED	7,864	7,864	13.00
14.00		69.00	EKG - CONTRACTED	1,141,637	12,356	14.00
15.00		69.03	SLEEP LAB - CONTRACTED	17,500	17,500	15.00
16.00		90.00	CLINIC - CONTRACTED	13,200	13,200	16.00
17.00		4.00	EMPLOYEE BENEFITS EXPENSE	906,336	906,336	17.00
18.00		5.00	BUSINESS OFFICE EXPENSE	191,517	191,517	18.00
200.00			TOTAL (lines 1.00 through 199.00)	6,964,036	5,713,389	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 3/28/2012 1:31 pm

		Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
		5.00	6.00	7.00	8.00	9.00	
1.00		0	0	0	0	0	1.00
2.00		0	0	0	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00		0	0	0	0	0	5.00
6.00		0	0	0	0	0	6.00
7.00		0	0	0	0	0	7.00
8.00		91,663	142,500	458	31,377	1,569	8.00
9.00		7,200	142,500	36	2,466	123	9.00
10.00		35	167,500	1	81	4	10.00
11.00		0	0	0	0	0	11.00
12.00		22,468	142,500	131	8,975	449	12.00
13.00		0	0	0	0	0	13.00
14.00		1,129,281	142,500	4,668	319,803	15,990	14.00
15.00		0	0	0	0	0	15.00
16.00		0	0	0	0	0	16.00
17.00		0	0	0	0	0	17.00
18.00		0	0	0	0	0	18.00
200.00		1,250,647		5,294	362,702	18,135	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 3/28/2012 1:31 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	31,377	8.00
9.00		0	0	0	0	2,466	9.00
10.00		0	0	0	0	81	10.00
11.00		0	0	0	0	0	11.00
12.00		0	0	0	0	8,975	12.00
13.00		0	0	0	0	0	13.00
14.00		0	0	0	0	319,803	14.00
15.00		0	0	0	0	0	15.00
16.00		0	0	0	0	0	16.00
17.00		0	0	0	0	0	17.00
18.00		0	0	0	0	0	18.00
200.00		0	0	0	0	362,702	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 3/28/2012 1:31 pm

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	1,322,248		1.00
2.00		0	2,489,568		2.00
3.00		0	196,525		3.00
4.00		0	59,460		4.00
5.00		0	158,700		5.00
6.00		0	15,355		6.00
7.00		0	29,815		7.00
8.00		60,286	88,573		8.00
9.00		4,734	4,734		9.00
10.00		0	114,658		10.00
11.00		0	150,000		11.00
12.00		13,493	13,493		12.00
13.00		0	7,864		13.00
14.00		809,478	821,834		14.00
15.00		0	17,500		15.00
16.00		0	13,200		16.00
17.00		0	906,336		17.00
18.00		0	191,517		18.00
200.00		887,991	6,601,380		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	5,040,845	5,040,845				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,905,840		5,905,840			2.00
4.00	EMPLOYEE BENEFITS	14,928,730	24,738	28,983	14,982,451		4.00
5.00	ADMINISTRATIVE & GENERAL	14,324,901	992,726	1,163,075	1,572,889	18,053,591	5.00
6.00	MAINTENANCE & REPAIRS	6,304,925	419,800	491,837	367,455	7,584,017	6.00
8.00	LAUNDRY & LINEN SERVICE	308,036	19,006	22,268	55,514	404,824	8.00
9.00	HOUSEKEEPING	1,147,509	14,114	16,536	238,030	1,416,189	9.00
10.00	DIETARY	449,767	68,396	80,132	78,118	676,413	10.00
11.00	CAFETERIA	656,267	14,509	16,998	167,239	855,013	11.00
13.00	NURSING ADMINISTRATION	779,060	9,901	11,600	179,328	979,889	13.00
14.00	CENTRAL SERVICES & SUPPLY	291,666	11,668	13,670	53,621	370,625	14.00
15.00	PHARMACY	9,159,456	39,773	46,598	310,452	9,556,279	15.00
16.00	MEDICAL RECORDS & LIBRARY	836,217	44,439	52,064	194,296	1,127,016	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,855,153	415,375	486,653	1,401,807	8,158,988	30.00
31.00	INTENSIVE CARE UNIT	2,408,305	151,840	177,896	579,426	3,317,467	31.00
40.00	SUBPROVIDER - IPF	1,058,743	42,657	49,977	258,605	1,409,982	40.00
41.00	SUBPROVIDER - IRF	651,416	62,554	73,288	150,873	938,131	41.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	1,158,610	82,269	96,386	280,543	1,617,808	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	4,086,364	274,320	321,392	817,105	5,499,181	50.00
52.00	DELIVERY ROOM & LABOR ROOM	417,599	31,660	37,093	88,722	575,074	52.00
53.00	ANESTHESIOLOGY	213,696	0	0	740,730	954,426	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,523,621	135,959	159,289	465,280	3,284,149	54.00
56.00	RADIOISOTOPE	644,942	12,961	15,185	46,287	719,375	56.00
60.00	LABORATORY	5,530,311	62,467	73,186	546,356	6,212,320	60.00
65.00	RESPIRATORY THERAPY	1,261,036	17,553	20,566	243,185	1,542,340	65.00
66.00	PHYSICAL THERAPY	1,788,478	61,817	72,424	387,235	2,309,954	66.00
69.00	ELECTROCARDIOLOGY	2,526,789	164,414	192,627	366,458	3,250,288	69.00
69.01	PULMONARY	60,760	4,586	5,372	15,166	85,884	69.01
69.02	CARDIOPULMONARY	103,304	12,858	15,065	24,747	155,974	69.02
69.03	SLEEP LAB	190,689	18,685	21,892	31,254	262,520	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,886,131	0	0	0	2,886,131	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	7,849,232	0	0	0	7,849,232	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	232,628	15,100	17,691	43,911	309,330	88.00
88.01	LOOGOOTEE (RHC)	418,700	48,396	56,701	98,566	622,363	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	449,451	377,041	441,740	52,049	1,320,281	90.00
90.01	IMED	340,139	33,866	39,677	103,636	517,318	90.01
90.02	ONCOLOGY	1,897,930	95,076	111,391	246,865	2,351,262	90.02
91.00	EMERGENCY	3,185,098	113,090	132,496	1,330,146	4,760,830	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	1,565,447	22,782	26,691	352,161	1,967,081	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	HOME HEALTH AGENCY	881,981	18,831	22,063	182,342	1,105,217	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	110,467	7,119	8,341	24,390	150,317	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	110,430,239	3,942,346	4,618,843	12,094,787	105,157,079	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,872	12,738	0	23,610	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	13,099,696	658,123	771,054	2,394,221	16,923,094	192.00
192.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	537,394	15,655	18,341	126,183	697,573	192.01
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	MEMORIAL HOSPITAL FOUNDATION	145,955	6,564	7,691	35,704	195,914	194.02
194.03	MKT/PHY SERVICES	1,878,225	66,417	77,814	224,117	2,246,573	194.03
194.04	COMMUNITY EDUCATION	391,208	47,418	55,554	68,148	562,328	194.04
194.06	MAB	0	0	0	0	0	194.06
194.08	PUBLIC RELATIONS	564,344	6,535	7,656	39,291	617,826	194.08
194.09	UNUSED SPACE	0	286,915	336,149	0	623,064	194.09
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	127,047,061	5,040,845	5,905,840	14,982,451	127,047,061	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	18,053,591					5.00
6.00	MAINTENANCE & REPAIRS	1,256,209	8,840,226				6.00
8.00	LAUNDRY & LINEN SERVICE	67,055	46,626	518,505			8.00
9.00	HOUSEKEEPING	234,576	34,625	0	1,685,390		9.00
10.00	DIETARY	112,040	167,787	0	32,285	988,525	10.00
11.00	CAFETERIA	141,623	35,592	0	6,849	0	11.00
13.00	NURSING ADMINISTRATION	162,308	24,289	0	4,674	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	61,390	28,624	1,911	5,508	0	14.00
15.00	PHARMACY	1,582,892	97,570	0	18,774	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	186,678	109,016	0	20,977	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,351,447	1,018,990	174,088	196,073	495,468	30.00
31.00	INTENSIVE CARE UNIT	549,502	372,491	55,222	71,674	184,569	31.00
40.00	SUBPROVIDER - IPF	233,548	104,645	9,176	20,136	74,861	40.00
41.00	SUBPROVIDER - IRF	155,391	153,457	13,400	29,528	56,984	41.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	267,972	201,820	36,067	38,834	176,643	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	910,879	672,956	89,737	129,489	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	95,255	77,669	3,348	14,945	0	52.00
53.00	ANESTHESIOLOGY	158,090	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	543,983	333,531	42,371	64,178	0	54.00
56.00	RADIOISOTOPE	119,157	31,795	0	6,118	0	56.00
60.00	LABORATORY	1,029,002	153,242	103	29,487	0	60.00
65.00	RESPIRATORY THERAPY	255,472	43,062	0	8,286	0	65.00
66.00	PHYSICAL THERAPY	382,618	151,647	7,253	29,180	0	66.00
69.00	ELECTROCARDIOLOGY	538,374	403,336	23,761	77,609	0	69.00
69.01	PULMONARY	14,226	11,249	0	2,165	0	69.01
69.02	CARDIOPULMONARY	25,835	31,544	0	6,070	0	69.02
69.03	SLEEP LAB	43,484	45,838	1,363	8,820	0	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	478,056	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	1,300,139	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	51,237	37,043	0	7,128	0	88.00
88.01	LOOGOOTEE (RHC)	103,088	118,724	0	22,845	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	218,690	924,949	0	177,977	0	90.00
90.01	IMED	85,688	83,078	108	15,986	0	90.01
90.02	ONCOLOGY	389,461	233,239	4,192	44,880	0	90.02
91.00	EMERGENCY	788,579	277,429	56,405	53,383	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	325,825	55,887	0	10,754	0	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	HOME HEALTH AGENCY	183,067	46,196	0	8,889	0	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	24,898	17,465	0	3,361	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	14,427,734	6,145,411	518,505	1,166,862	988,525	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,911	26,672	0	5,132	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	2,803,147	1,614,493	0	310,653	0	192.00
192.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	115,545	38,404	0	7,390	0	192.01
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	MEMORIAL HOSPITAL FOUNDATION	32,451	16,103	0	3,099	0	194.02
194.03	MKT/PHY SERVICES	372,120	162,932	0	31,351	0	194.03
194.04	COMMUNITY EDUCATION	93,143	116,324	0	22,383	0	194.04
194.06	MAB	0	0	0	0	0	194.06
194.08	PUBLIC RELATIONS	102,336	16,032	0	3,085	0	194.08
194.09	UNUSED SPACE	103,204	703,855	0	135,435	0	194.09
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	18,053,591	8,840,226	518,505	1,685,390	988,525	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	1,039,077					11.00
13.00	NURSING ADMINISTRATION	14,917	1,186,077				13.00
14.00	CENTRAL SERVICES & SUPPLY	10,321	0	478,379			14.00
15.00	PHARMACY	23,342	0	0	11,278,857		15.00
16.00	MEDICAL RECORDS & LIBRARY	28,073	0	0	24	1,471,784	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	143,700	616,416	0	1,332	94,136	30.00
31.00	INTENSIVE CARE UNIT	55,837	239,515	0	135	30,865	31.00
40.00	SUBPROVIDER - IPF	19,797	84,920	0	16	11,349	40.00
41.00	SUBPROVIDER - IRF	15,601	66,921	0	10	8,596	41.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	32,376	0	0	37	7,110	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	80,713	0	0	38,715	159,371	50.00
52.00	DELIVERY ROOM & LABOR ROOM	7,909	33,927	0	0	8,901	52.00
53.00	ANESTHESIOLOGY	16,264	0	0	43	16,234	53.00
54.00	RADIOLOGY-DIAGNOSTIC	47,405	0	0	177,600	195,725	54.00
56.00	RADIOISOTOPE	3,238	0	0	0	31,439	56.00
60.00	LABORATORY	66,219	0	0	84	134,349	60.00
65.00	RESPIRATORY THERAPY	25,356	0	0	94,154	18,018	65.00
66.00	PHYSICAL THERAPY	37,492	0	0	3,169	27,398	66.00
69.00	ELECTROCARDIOLOGY	34,779	0	0	1,155	105,243	69.00
69.01	PULMONARY	1,364	0	0	0	2,772	69.01
69.02	CARDIOPULMONARY	2,577	0	0	0	2,938	69.02
69.03	SLEEP LAB	3,610	0	0	0	5,927	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	478,379	0	57,376	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	78,222	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	10,691,969	315,996	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	4,216	0	0	10,447	2,720	88.00
88.01	LOOGOOTEE (RHC)	7,137	0	0	13,971	5,253	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	5,929	0	0	2,513	8,069	90.00
90.01	IMED	7,761	33,290	0	64,184	4,655	90.01
90.02	ONCOLOGY	25,897	111,088	0	0	48,332	90.02
91.00	EMERGENCY	58,875	0	0	10,178	63,030	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	50,377	0	0	11,014	13,074	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	HOME HEALTH AGENCY	18,045	0	0	727	7,779	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	1,513	0	0	6	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	850,640	1,186,077	478,379	11,121,483	1,464,877	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	134,626	0	0	156,325	0	192.00
192.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	7,560	0	0	0	6,907	192.01
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	MEMORIAL HOSPITAL FOUNDATION	2,672	0	0	0	0	194.02
194.03	MKT/PHY SERVICES	30,437	0	0	1	0	194.03
194.04	COMMUNITY EDUCATION	9,386	0	0	1,048	0	194.04
194.06	MAB	0	0	0	0	0	194.06
194.08	PUBLIC RELATIONS	3,756	0	0	0	0	194.08
194.09	UNUSED SPACE	0	0	0	0	0	194.09
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,039,077	1,186,077	478,379	11,278,857	1,471,784	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
6.00	MAINTENANCE & REPAIRS					6.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
14.00	CENTRAL SERVICES & SUPPLY					14.00
15.00	PHARMACY					15.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	12,250,638	0	12,250,638		30.00
31.00	INTENSIVE CARE UNIT	4,877,277	0	4,877,277		31.00
40.00	SUBPROVIDER - IPF	1,968,430	0	1,968,430		40.00
41.00	SUBPROVIDER - IRF	1,438,019	0	1,438,019		41.00
43.00	NURSERY	0	0	0		43.00
44.00	SKILLED NURSING FACILITY	2,378,667	0	2,378,667		44.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	7,581,041	0	7,581,041		50.00
52.00	DELIVERY ROOM & LABOR ROOM	817,028	0	817,028		52.00
53.00	ANESTHESIOLOGY	1,145,057	0	1,145,057		53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,688,942	0	4,688,942		54.00
56.00	RADIOISOTOPE	911,122	0	911,122		56.00
60.00	LABORATORY	7,624,806	0	7,624,806		60.00
65.00	RESPIRATORY THERAPY	1,986,688	0	1,986,688		65.00
66.00	PHYSICAL THERAPY	2,948,711	0	2,948,711		66.00
69.00	ELECTROCARDIOLOGY	4,434,545	0	4,434,545		69.00
69.01	PULMONARY	117,660	0	117,660		69.01
69.02	CARDIOPULMONARY	224,938	0	224,938		69.02
69.03	SLEEP LAB	371,562	0	371,562		69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,899,942	0	3,899,942		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	9,227,593	0	9,227,593		72.00
73.00	DRUGS CHARGED TO PATIENTS	11,007,965	0	11,007,965		73.00
74.00	RENAL DIALYSIS	0	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	FRENCH LICK (RHC)	422,121	0	422,121		88.00
88.01	LOOGOOTEE (RHC)	893,381	0	893,381		88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	2,658,408	0	2,658,408		90.00
90.01	IMED	812,068	0	812,068		90.01
90.02	ONCOLOGY	3,208,351	0	3,208,351		90.02
91.00	EMERGENCY	6,068,709	0	6,068,709		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES	2,434,012	0	2,434,012		95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
101.00	HOME HEALTH AGENCY	1,369,920	0	1,369,920		101.00
	SPECIAL PURPOSE COST CENTERS					
116.00	HOSPICE	197,560	0	197,560		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	97,965,161	0	97,965,161		118.00
	NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	59,325	0	59,325		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	21,942,338	0	21,942,338		192.00
192.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	873,379	0	873,379		192.01
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.02	MEMORIAL HOSPITAL FOUNDATION	250,239	0	250,239		194.02
194.03	MKT/PHY SERVICES	2,843,414	0	2,843,414		194.03
194.04	COMMUNITY EDUCATION	804,612	0	804,612		194.04
194.06	MAB	0	0	0		194.06
194.08	PUBLIC RELATIONS	743,035	0	743,035		194.08
194.09	UNUSED SPACE	1,565,558	0	1,565,558		194.09
200.00	Cross Foot Adjustments	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	127,047,061	0	127,047,061		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	0	24,738	28,983	53,721	53,721	4.00
5.00	ADMINISTRATIVE & GENERAL	0	992,726	1,163,075	2,155,801	5,640	5.00
6.00	MAINTENANCE & REPAIRS	0	419,800	491,837	911,637	1,318	6.00
8.00	LAUNDRY & LINEN SERVICE	0	19,006	22,268	41,274	199	8.00
9.00	HOUSEKEEPING	0	14,114	16,536	30,650	853	9.00
10.00	DIETARY	0	68,396	80,132	148,528	280	10.00
11.00	CAFETERIA	0	14,509	16,998	31,507	600	11.00
13.00	NURSING ADMINISTRATION	0	9,901	11,600	21,501	643	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	11,668	13,670	25,338	192	14.00
15.00	PHARMACY	0	39,773	46,598	86,371	1,113	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	44,439	52,064	96,503	697	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	415,375	486,653	902,028	5,026	30.00
31.00	INTENSIVE CARE UNIT	0	151,840	177,896	329,736	2,078	31.00
40.00	SUBPROVIDER - IPF	0	42,657	49,977	92,634	927	40.00
41.00	SUBPROVIDER - IRF	0	62,554	73,288	135,842	541	41.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	82,269	96,386	178,655	1,006	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	274,320	321,392	595,712	2,930	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	31,660	37,093	68,753	318	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	2,656	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	135,959	159,289	295,248	1,668	54.00
56.00	RADIOISOTOPE	0	12,961	15,185	28,146	166	56.00
60.00	LABORATORY	0	62,467	73,186	135,653	1,959	60.00
65.00	RESPIRATORY THERAPY	0	17,553	20,566	38,119	872	65.00
66.00	PHYSICAL THERAPY	0	61,817	72,424	134,241	1,388	66.00
69.00	ELECTROCARDIOLOGY	0	164,414	192,627	357,041	1,314	69.00
69.01	PULMONARY	0	4,586	5,372	9,958	54	69.01
69.02	CARDIOPULMONARY	0	12,858	15,065	27,923	89	69.02
69.03	SLEEP LAB	0	18,685	21,892	40,577	112	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	0	15,100	17,691	32,791	157	88.00
88.01	LOOGOOTEE (RHC)	0	48,396	56,701	105,097	353	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	377,041	441,740	818,781	187	90.00
90.01	IMED	0	33,866	39,677	73,543	372	90.01
90.02	ONCOLOGY	0	95,076	111,391	206,467	885	90.02
91.00	EMERGENCY	0	113,090	132,496	245,586	4,769	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	22,782	26,691	49,473	1,263	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	HOME HEALTH AGENCY	0	18,831	22,063	40,894	654	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	0	7,119	8,341	15,460	87	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	3,942,346	4,618,843	8,561,189	43,366	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,872	12,738	23,610	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	658,123	771,054	1,429,177	8,586	192.00
192.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	15,655	18,341	33,996	452	192.01
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	MEMORIAL HOSPITAL FOUNDATION	0	6,564	7,691	14,255	128	194.02
194.03	MKT/PHY SERVICES	0	66,417	77,814	144,231	804	194.03
194.04	COMMUNITY EDUCATION	0	47,418	55,554	102,972	244	194.04
194.06	MAB	0	0	0	0	0	194.06
194.08	PUBLIC RELATIONS	0	6,535	7,656	14,191	141	194.08
194.09	UNUSED SPACE	0	286,915	336,149	623,064	0	194.09
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	5,040,845	5,905,840	10,946,685	53,721	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	2,161,441					5.00
6.00	MAINTENANCE & REPAIRS	150,399	1,063,354				6.00
8.00	LAUNDRY & LINEN SERVICE	8,028	5,608	55,109			8.00
9.00	HOUSEKEEPING	28,084	4,165	0	63,752		9.00
10.00	DIETARY	13,414	20,182	0	1,221	183,625	10.00
11.00	CAFETERIA	16,956	4,281	0	259	0	11.00
13.00	NURSING ADMINISTRATION	19,432	2,922	0	177	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	7,350	3,443	203	208	0	14.00
15.00	PHARMACY	189,511	11,736	0	710	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	22,350	13,113	0	793	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	161,801	122,570	18,503	7,417	92,036	30.00
31.00	INTENSIVE CARE UNIT	65,789	44,805	5,869	2,711	34,285	31.00
40.00	SUBPROVIDER - IPF	27,961	12,587	975	762	13,906	40.00
41.00	SUBPROVIDER - IRF	18,604	18,459	1,424	1,117	10,585	41.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	32,083	24,276	3,833	1,469	32,813	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	109,054	80,947	9,538	4,898	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	11,404	9,342	356	565	0	52.00
53.00	ANESTHESIOLOGY	18,927	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	65,128	40,119	4,503	2,428	0	54.00
56.00	RADIOISOTOPE	14,266	3,824	0	231	0	56.00
60.00	LABORATORY	123,197	18,433	11	1,115	0	60.00
65.00	RESPIRATORY THERAPY	30,586	5,180	0	313	0	65.00
66.00	PHYSICAL THERAPY	45,809	18,241	771	1,104	0	66.00
69.00	ELECTROCARDIOLOGY	64,456	48,516	2,525	2,936	0	69.00
69.01	PULMONARY	1,703	1,353	0	82	0	69.01
69.02	CARDIOPULMONARY	3,093	3,794	0	230	0	69.02
69.03	SLEEP LAB	5,206	5,514	145	334	0	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,235	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	155,658	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	6,134	4,456	0	270	0	88.00
88.01	LOOGOOTEE (RHC)	12,342	14,281	0	864	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	26,182	111,258	0	6,732	0	90.00
90.01	IMED	10,259	9,993	12	605	0	90.01
90.02	ONCOLOGY	46,628	28,055	446	1,698	0	90.02
91.00	EMERGENCY	94,412	33,371	5,995	2,019	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	39,009	6,722	0	407	0	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	HOME HEALTH AGENCY	21,918	5,557	0	336	0	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	2,981	2,101	0	127	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,727,349	739,204	55,109	44,138	183,625	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	468	3,208	0	194	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	335,593	194,203	0	11,750	0	192.00
192.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	13,834	4,620	0	280	0	192.01
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	MEMORIAL HOSPITAL FOUNDATION	3,885	1,937	0	117	0	194.02
194.03	MKT/PHY SERVICES	44,552	19,598	0	1,186	0	194.03
194.04	COMMUNITY EDUCATION	11,152	13,992	0	847	0	194.04
194.06	MAB	0	0	0	0	0	194.06
194.08	PUBLIC RELATIONS	12,252	1,928	0	117	0	194.08
194.09	UNUSED SPACE	12,356	84,664	0	5,123	0	194.09
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,161,441	1,063,354	55,109	63,752	183,625	202.00

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	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	53,603					11.00
13.00	NURSING ADMINISTRATION	770	45,445				13.00
14.00	CENTRAL SERVICES & SUPPLY	532	0	37,266			14.00
15.00	PHARMACY	1,204	0	0	290,645		15.00
16.00	MEDICAL RECORDS & LIBRARY	1,448	0	0	1	134,905	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	7,416	23,618	0	34	8,637	30.00
31.00	INTENSIVE CARE UNIT	2,880	9,177	0	3	2,832	31.00
40.00	SUBPROVIDER - IPF	1,021	3,254	0	0	1,041	40.00
41.00	SUBPROVIDER - IRF	805	2,564	0	0	789	41.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	1,670	0	0	1	652	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	4,164	0	0	998	14,622	50.00
52.00	DELIVERY ROOM & LABOR ROOM	408	1,300	0	0	817	52.00
53.00	ANESTHESIOLOGY	839	0	0	1	1,489	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,445	0	0	4,577	17,957	54.00
56.00	RADIOISOTOPE	167	0	0	0	2,884	56.00
60.00	LABORATORY	3,416	0	0	2	12,326	60.00
65.00	RESPIRATORY THERAPY	1,308	0	0	2,426	1,653	65.00
66.00	PHYSICAL THERAPY	1,934	0	0	82	2,514	66.00
69.00	ELECTROCARDIOLOGY	1,794	0	0	30	9,656	69.00
69.01	PULMONARY	70	0	0	0	254	69.01
69.02	CARDIOPULMONARY	133	0	0	0	270	69.02
69.03	SLEEP LAB	186	0	0	0	544	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	37,266	0	5,264	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	7,177	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	275,522	28,864	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	217	0	0	269	250	88.00
88.01	LOOGOOTEE (RHC)	368	0	0	360	482	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	306	0	0	65	740	90.00
90.01	IMED	400	1,276	0	1,654	427	90.01
90.02	ONCOLOGY	1,336	4,256	0	0	4,434	90.02
91.00	EMERGENCY	3,037	0	0	262	5,783	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	2,599	0	0	284	1,199	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	HOME HEALTH AGENCY	931	0	0	19	714	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	78	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	43,882	45,445	37,266	286,590	134,271	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	6,945	0	0	4,028	0	192.00
192.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	390	0	0	0	634	192.01
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	MEMORIAL HOSPITAL FOUNDATION	138	0	0	0	0	194.02
194.03	MKT/PHY SERVICES	1,570	0	0	0	0	194.03
194.04	COMMUNITY EDUCATION	484	0	0	27	0	194.04
194.06	MAB	0	0	0	0	0	194.06
194.08	PUBLIC RELATIONS	194	0	0	0	0	194.08
194.09	UNUSED SPACE	0	0	0	0	0	194.09
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	53,603	45,445	37,266	290,645	134,905	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
6.00	MAINTENANCE & REPAIRS					6.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
14.00	CENTRAL SERVICES & SUPPLY					14.00
15.00	PHARMACY					15.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	1,349,086	0	1,349,086		30.00
31.00	INTENSIVE CARE UNIT	500,165	0	500,165		31.00
40.00	SUBPROVIDER - IPF	155,068	0	155,068		40.00
41.00	SUBPROVIDER - IRF	190,730	0	190,730		41.00
43.00	NURSERY	0	0	0		43.00
44.00	SKILLED NURSING FACILITY	276,458	0	276,458		44.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	822,863	0	822,863		50.00
52.00	DELIVERY ROOM & LABOR ROOM	93,263	0	93,263		52.00
53.00	ANESTHESIOLOGY	23,912	0	23,912		53.00
54.00	RADIOLOGY-DIAGNOSTIC	434,073	0	434,073		54.00
56.00	RADIOISOTOPE	49,684	0	49,684		56.00
60.00	LABORATORY	296,112	0	296,112		60.00
65.00	RESPIRATORY THERAPY	80,457	0	80,457		65.00
66.00	PHYSICAL THERAPY	206,084	0	206,084		66.00
69.00	ELECTROCARDIOLOGY	488,268	0	488,268		69.00
69.01	PULMONARY	13,474	0	13,474		69.01
69.02	CARDIOPULMONARY	35,532	0	35,532		69.02
69.03	SLEEP LAB	52,618	0	52,618		69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,765	0	99,765		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	162,835	0	162,835		72.00
73.00	DRUGS CHARGED TO PATIENTS	304,386	0	304,386		73.00
74.00	RENAL DIALYSIS	0	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	FRENCH LICK (RHC)	44,544	0	44,544		88.00
88.01	LOOGOOTEE (RHC)	134,147	0	134,147		88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	964,251	0	964,251		90.00
90.01	IMED	98,541	0	98,541		90.01
90.02	ONCOLOGY	294,205	0	294,205		90.02
91.00	EMERGENCY	395,234	0	395,234		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES	100,956	0	100,956		95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
101.00	HOME HEALTH AGENCY	71,023	0	71,023		101.00
	SPECIAL PURPOSE COST CENTERS					
116.00	HOSPICE	20,834	0	20,834		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	7,758,568	0	7,758,568		118.00
	NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,480	0	27,480		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	1,990,282	0	1,990,282		192.00
192.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	54,206	0	54,206		192.01
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.02	MEMORIAL HOSPITAL FOUNDATION	20,460	0	20,460		194.02
194.03	MKT/PHY SERVICES	211,941	0	211,941		194.03
194.04	COMMUNITY EDUCATION	129,718	0	129,718		194.04
194.06	MAB	0	0	0		194.06
194.08	PUBLIC RELATIONS	28,823	0	28,823		194.08
194.09	UNUSED SPACE	725,207	0	725,207		194.09
200.00	Cross Foot Adjustments	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	10,946,685	0	10,946,685		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	690,360					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		690,360				2.00
4.00	EMPLOYEE BENEFITS	3,388	3,388	60,023,480			4.00
5.00	ADMINISTRATIVE & GENERAL	135,957	135,957	6,301,385	-18,053,591	108,993,470	5.00
6.00	MAINTENANCE & REPAIRS	57,493	57,493	1,472,117	0	7,584,017	6.00
8.00	LAUNDRY & LINEN SERVICE	2,603	2,603	222,402	0	404,824	8.00
9.00	HOUSEKEEPING	1,933	1,933	953,606	0	1,416,189	9.00
10.00	DIETARY	9,367	9,367	312,961	0	676,413	10.00
11.00	CAFETERIA	1,987	1,987	670,002	0	855,013	11.00
13.00	NURSING ADMINISTRATION	1,356	1,356	718,431	0	979,889	13.00
14.00	CENTRAL SERVICES & SUPPLY	1,598	1,598	214,818	0	370,625	14.00
15.00	PHARMACY	5,447	5,447	1,243,750	0	9,556,279	15.00
16.00	MEDICAL RECORDS & LIBRARY	6,086	6,086	778,397	0	1,127,016	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	56,887	56,887	5,615,990	0	8,158,988	30.00
31.00	INTENSIVE CARE UNIT	20,795	20,795	2,321,327	0	3,317,467	31.00
40.00	SUBPROVIDER - IPF	5,842	5,842	1,036,036	0	1,409,982	40.00
41.00	SUBPROVIDER - IRF	8,567	8,567	604,434	0	938,131	41.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	11,267	11,267	1,123,926	0	1,617,808	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	37,569	37,569	3,273,525	0	5,499,181	50.00
52.00	DELIVERY ROOM & LABOR ROOM	4,336	4,336	355,441	0	575,074	52.00
53.00	ANESTHESIOLOGY	0	0	2,967,550	0	954,426	53.00
54.00	RADIOLOGY-DIAGNOSTIC	18,620	18,620	1,864,029	0	3,284,149	54.00
56.00	RADIOISOTOPE	1,775	1,775	185,437	0	719,375	56.00
60.00	LABORATORY	8,555	8,555	2,188,840	0	6,212,320	60.00
65.00	RESPIRATORY THERAPY	2,404	2,404	974,259	0	1,542,340	65.00
66.00	PHYSICAL THERAPY	8,466	8,466	1,551,359	0	2,309,954	66.00
69.00	ELECTROCARDIOLOGY	22,517	22,517	1,468,124	0	3,250,288	69.00
69.01	PULMONARY	628	628	60,760	0	85,884	69.01
69.02	CARDIOPULMONARY	1,761	1,761	99,141	0	155,974	69.02
69.03	SLEEP LAB	2,559	2,559	125,212	0	262,520	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,886,131	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	7,849,232	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	2,068	2,068	175,918	0	309,330	88.00
88.01	LOOGOOTEE (RHC)	6,628	6,628	394,880	0	622,363	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	51,637	51,637	208,523	0	1,320,281	90.00
90.01	IMED	4,638	4,638	415,191	0	517,318	90.01
90.02	ONCOLOGY	13,021	13,021	989,001	0	2,351,262	90.02
91.00	EMERGENCY	15,488	15,488	5,328,897	0	4,760,830	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	3,120	3,120	1,410,846	0	1,967,081	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	HOME HEALTH AGENCY	2,579	2,579	730,509	0	1,105,217	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	975	975	97,711	0	150,317	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	539,917	539,917	48,454,735	-18,053,591	87,103,488	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,489	1,489	0	0	23,610	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	90,132	90,132	9,591,889	0	16,923,094	192.00
192.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,144	2,144	505,522	0	697,573	192.01
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	MEMORIAL HOSPITAL FOUNDATION	899	899	143,040	0	195,914	194.02
194.03	MKT/PHY SERVICES	9,096	9,096	897,868	0	2,246,573	194.03
194.04	COMMUNITY EDUCATION	6,494	6,494	273,018	0	562,328	194.04
194.06	MAB	0	0	0	0	0	194.06
194.08	PUBLIC RELATIONS	895	895	157,408	0	617,826	194.08
194.09	UNUSED SPACE	39,294	39,294	0	0	623,064	194.09
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	5,040,845	5,905,840	14,982,451		18,053,591	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7.301763	8.554725	0.249610		0.165639	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
204.00	Cost to be allocated (per Wkst. B, Part II)			53,721		2,161,441	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000895		0.019831	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
		6.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS	493,522					6.00
8.00	LAUNDRY & LINEN SERVICE	2,603	885,075				8.00
9.00	HOUSEKEEPING	1,933	0	488,986			9.00
10.00	DIETARY	9,367	0	9,367	28,311		10.00
11.00	CAFETERIA	1,987	0	1,987	0	1,693,594	11.00
13.00	NURSING ADMINISTRATION	1,356	0	1,356	0	24,313	13.00
14.00	CENTRAL SERVICES & SUPPLY	1,598	3,262	1,598	0	16,822	14.00
15.00	PHARMACY	5,447	0	5,447	0	38,045	15.00
16.00	MEDICAL RECORDS & LIBRARY	6,086	0	6,086	0	45,756	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	56,887	297,164	56,887	14,190	234,218	30.00
31.00	INTENSIVE CARE UNIT	20,795	94,262	20,795	5,286	91,008	31.00
40.00	SUBPROVIDER - IPF	5,842	15,663	5,842	2,144	32,267	40.00
41.00	SUBPROVIDER - IRF	8,567	22,874	8,567	1,632	25,428	41.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	11,267	61,565	11,267	5,059	52,770	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	37,569	153,179	37,569	0	131,555	50.00
52.00	DELIVERY ROOM & LABOR ROOM	4,336	5,715	4,336	0	12,891	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	26,509	53.00
54.00	RADIOLOGY-DIAGNOSTIC	18,620	72,327	18,620	0	77,265	54.00
56.00	RADIOISOTOPE	1,775	0	1,775	0	5,278	56.00
60.00	LABORATORY	8,555	175	8,555	0	107,930	60.00
65.00	RESPIRATORY THERAPY	2,404	0	2,404	0	41,328	65.00
66.00	PHYSICAL THERAPY	8,466	12,380	8,466	0	61,108	66.00
69.00	ELECTROCARDIOLOGY	22,517	40,560	22,517	0	56,686	69.00
69.01	PULMONARY	628	0	628	0	2,223	69.01
69.02	CARDIOPULMONARY	1,761	0	1,761	0	4,201	69.02
69.03	SLEEP LAB	2,559	2,327	2,559	0	5,884	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	2,068	0	2,068	0	6,872	88.00
88.01	LOOGOOTEE (RHC)	6,628	0	6,628	0	11,632	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	51,637	0	51,637	0	9,664	90.00
90.01	IMED	4,638	185	4,638	0	12,649	90.01
90.02	ONCOLOGY	13,021	7,155	13,021	0	42,210	90.02
91.00	EMERGENCY	15,488	96,282	15,488	0	95,961	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	3,120	0	3,120	0	82,109	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	HOME HEALTH AGENCY	2,579	0	2,579	0	29,411	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	975	0	975	0	2,466	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	343,079	885,075	338,543	28,311	1,386,459	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,489	0	1,489	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	90,132	0	90,132	0	219,427	192.00
192.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,144	0	2,144	0	12,322	192.01
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	MEMORIAL HOSPITAL FOUNDATION	899	0	899	0	4,355	194.02
194.03	MKT/PHY SERVICES	9,096	0	9,096	0	49,610	194.03
194.04	COMMUNITY EDUCATION	6,494	0	6,494	0	15,299	194.04
194.06	MAB	0	0	0	0	0	194.06
194.08	PUBLIC RELATIONS	895	0	895	0	6,122	194.08
194.09	UNUSED SPACE	39,294	0	39,294	0	0	194.09
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	8,840,226	518,505	1,685,390	988,525	1,039,077	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	17.912527	0.585832	3.446704	34.916640	0.613534	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,063,354	55,109	63,752	183,625	53,603	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.154623	0.062265	0.130376	6.485995	0.031650	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)		
		13.00	14.00	15.00	16.00		
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION	450,671					13.00
14.00	CENTRAL SERVICES & SUPPLY	0	100				14.00
15.00	PHARMACY	0	0	7,923,016			15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	17	237,714,519		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	234,218	0	936	15,205,274		30.00
31.00	INTENSIVE CARE UNIT	91,008	0	95	4,985,395		31.00
40.00	SUBPROVIDER - IPF	32,267	0	11	1,833,115		40.00
41.00	SUBPROVIDER - IRF	25,428	0	7	1,388,500		41.00
43.00	NURSERY	0	0	0	0		43.00
44.00	SKILLED NURSING FACILITY	0	0	26	1,148,365		44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	27,196	25,742,294		50.00
52.00	DELIVERY ROOM & LABOR ROOM	12,891	0	0	1,437,750		52.00
53.00	ANESTHESIOLOGY	0	0	30	2,622,171		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	124,758	31,614,435		54.00
56.00	RADIOISOTOPE	0	0	0	5,078,151		56.00
60.00	LABORATORY	0	0	59	21,700,749		60.00
65.00	RESPIRATORY THERAPY	0	0	66,140	2,910,303		65.00
66.00	PHYSICAL THERAPY	0	0	2,226	4,425,471		66.00
69.00	ELECTROCARDIOLOGY	0	0	811	16,999,301		69.00
69.01	PULMONARY	0	0	0	447,753		69.01
69.02	CARDIOPULMONARY	0	0	0	474,626		69.02
69.03	SLEEP LAB	0	0	0	957,316		69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	100	0	9,267,652		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,634,797		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	7,510,747	51,026,484		73.00
74.00	RENAL DIALYSIS	0	0	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	0	0	7,339	439,425		88.00
88.01	LOOGOOTEE (RHC)	0	0	9,814	848,476		88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	CLINIC	0	0	1,765	1,303,376		90.00
90.01	IMED	12,649	0	45,087	751,952		90.01
90.02	ONCOLOGY	42,210	0	0	7,806,748		90.02
91.00	EMERGENCY	0	0	7,150	10,180,861		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	7,737	2,111,698		95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96.00
101.00	HOME HEALTH AGENCY	0	0	511	1,256,433		101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	0	0	4	0		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	450,671	100	7,812,466	236,598,871		118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	109,813	0		192.00
192.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,115,648		192.01
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.02	MEMORIAL HOSPITAL FOUNDATION	0	0	0	0		194.02
194.03	MKT/PHY SERVICES	0	0	1	0		194.03
194.04	COMMUNITY EDUCATION	0	0	736	0		194.04
194.06	MAB	0	0	0	0		194.06
194.08	PUBLIC RELATIONS	0	0	0	0		194.08
194.09	UNUSED SPACE	0	0	0	0		194.09
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,186,077	478,379	11,278,857	1,471,784		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2.631802	4,783.790000	1.423556	0.006191		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	45,445	37,266	290,645	134,905		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)		
		13.00	14.00	15.00	16.00		
205.00	Unit cost multiplier (Wkst. B, Part II)	0.100839	372.660000	0.036684	0.000568		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 3/28/2012 1:31 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	12,250,638		12,250,638	0	12,250,638	30.00
31.00	INTENSIVE CARE UNIT	4,877,277		4,877,277	0	4,877,277	31.00
40.00	SUBPROVIDER - IPF	1,968,430		1,968,430	0	1,968,430	40.00
41.00	SUBPROVIDER - IRF	1,438,019		1,438,019	60,286	1,498,305	41.00
43.00	NURSERY	0		0	0	0	43.00
44.00	SKILLED NURSING FACILITY	2,378,667		2,378,667	4,734	2,383,401	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	7,581,041		7,581,041	0	7,581,041	50.00
52.00	DELIVERY ROOM & LABOR ROOM	817,028		817,028	0	817,028	52.00
53.00	ANESTHESIOLOGY	1,145,057		1,145,057	0	1,145,057	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,688,942		4,688,942	0	4,688,942	54.00
56.00	RADIOISOTOPE	911,122		911,122	0	911,122	56.00
60.00	LABORATORY	7,624,806		7,624,806	0	7,624,806	60.00
65.00	RESPIRATORY THERAPY	1,986,688	0	1,986,688	13,493	2,000,181	65.00
66.00	PHYSICAL THERAPY	2,948,711	0	2,948,711	0	2,948,711	66.00
69.00	ELECTROCARDIOLOGY	4,434,545		4,434,545	809,478	5,244,023	69.00
69.01	PULMONARY	117,660		117,660	0	117,660	69.01
69.02	CARDIOPULMONARY	224,938		224,938	0	224,938	69.02
69.03	SLEEP LAB	371,562		371,562	0	371,562	69.03
70.00	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,899,942		3,899,942	0	3,899,942	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	9,227,593		9,227,593	0	9,227,593	72.00
73.00	DRUGS CHARGED TO PATIENTS	11,007,965		11,007,965	0	11,007,965	73.00
74.00	RENAL DIALYSIS	0		0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	422,121		422,121	0	422,121	88.00
88.01	LOOGOOTEE (RHC)	893,381		893,381	0	893,381	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	CLINIC	2,658,408		2,658,408	0	2,658,408	90.00
90.01	IMED	812,068		812,068	0	812,068	90.01
90.02	ONCOLOGY	3,208,351		3,208,351	0	3,208,351	90.02
91.00	EMERGENCY	6,068,709		6,068,709	0	6,068,709	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	975,457		975,457		975,457	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	2,434,012		2,434,012	0	2,434,012	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
101.00	HOME HEALTH AGENCY	1,369,920		1,369,920		1,369,920	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	197,560		197,560		197,560	116.00
200.00	Subtotal (see instructions)	98,940,618	0	98,940,618	887,991	99,828,609	200.00
201.00	Less Observation Beds	975,457		975,457		975,457	201.00
202.00	Total (see instructions)	97,965,161	0	97,965,161	887,991	98,853,152	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 3/28/2012 1:31 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	15,205,274		15,205,274			30.00
31.00	INTENSIVE CARE UNIT	4,985,395		4,985,395			31.00
40.00	SUBPROVIDER - IPF	1,833,115		1,833,115			40.00
41.00	SUBPROVIDER - IRF	1,388,500		1,388,500			41.00
43.00	NURSERY	0		0			43.00
44.00	SKILLED NURSING FACILITY	1,148,365		1,148,365			44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	5,542,669	20,199,625	25,742,294	0.294497	0.000000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	1,153,824	283,926	1,437,750	0.568268	0.000000	52.00
53.00	ANESTHESIOLOGY	819,025	1,803,146	2,622,171	0.436683	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,885,936	26,728,499	31,614,435	0.148316	0.000000	54.00
56.00	RADIOISOTOPE	536,641	4,541,510	5,078,151	0.179420	0.000000	56.00
60.00	LABORATORY	6,212,348	15,488,401	21,700,749	0.351361	0.000000	60.00
65.00	RESPIRATORY THERAPY	1,648,405	1,261,898	2,910,303	0.682640	0.000000	65.00
66.00	PHYSICAL THERAPY	2,866,614	1,558,857	4,425,471	0.666304	0.000000	66.00
69.00	ELECTROCARDIOLOGY	7,176,942	9,822,359	16,999,301	0.260866	0.000000	69.00
69.01	PULMONARY	79,428	368,325	447,753	0.262779	0.000000	69.01
69.02	CARDIOPULMONARY	327	474,299	474,626	0.473927	0.000000	69.02
69.03	SLEEP LAB	1,766	955,550	957,316	0.388129	0.000000	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,018,889	4,248,763	9,267,652	0.420812	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	9,747,956	2,886,841	12,634,797	0.730332	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	24,917,634	26,108,850	51,026,484	0.215730	0.000000	73.00
74.00	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	0	439,425	439,425			88.00
88.01	LOOGOOTEE (RHC)	0	848,476	848,476			88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	CLINIC	18,150	1,285,226	1,303,376	2.039632	0.000000	90.00
90.01	IMED	0	751,952	751,952	1.079947	0.000000	90.01
90.02	ONCOLOGY	196,251	7,610,497	7,806,748	0.410972	0.000000	90.02
91.00	EMERGENCY	2,244,911	7,935,950	10,180,861	0.596090	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	230,000	728,273	958,273	1.017932	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	749,870	1,361,828	2,111,698	1.152633	0.000000	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
101.00	HOME HEALTH AGENCY	0	1,256,433	1,256,433			101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	0	0	0			116.00
200.00	Subtotal (see instructions)	98,608,235	138,948,909	237,557,144			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	98,608,235	138,948,909	237,557,144			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 150115	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	PPS Inpatient Ratio		
		11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
40.00	SUBPROVIDER - IPF			40.00
41.00	SUBPROVIDER - IRF			41.00
43.00	NURSERY			43.00
44.00	SKILLED NURSING FACILITY			44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0.294497		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.568268		52.00
53.00	ANESTHESIOLOGY	0.436683		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.148316		54.00
56.00	RADIOISOTOPE	0.179420		56.00
60.00	LABORATORY	0.351361		60.00
65.00	RESPIRATORY THERAPY	0.687276		65.00
66.00	PHYSICAL THERAPY	0.666304		66.00
69.00	ELECTROCARDIOLOGY	0.308485		69.00
69.01	PULMONARY	0.262779		69.01
69.02	CARDIOPULMONARY	0.473927		69.02
69.03	SLEEP LAB	0.388129		69.03
70.00	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.420812		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.730332		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.215730		73.00
74.00	RENAL DIALYSIS	0.000000		74.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	FRENCH LICK (RHC)			88.00
88.01	LOOGOOTEE (RHC)			88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	CLINIC	2.039632		90.00
90.01	IMED	1.079947		90.01
90.02	ONCOLOGY	0.410972		90.02
91.00	EMERGENCY	0.596090		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.017932		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	1.152633		95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
101.00	HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
116.00	HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 3/28/2012 1:31 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	12,250,638		12,250,638	0	0	30.00
31.00	INTENSIVE CARE UNIT	4,877,277		4,877,277	0	0	31.00
40.00	SUBPROVIDER - IPF	1,968,430		1,968,430	0	0	40.00
41.00	SUBPROVIDER - IRF	1,438,019		1,438,019	0	0	41.00
43.00	NURSERY	0		0	0	0	43.00
44.00	SKILLED NURSING FACILITY	2,378,667		2,378,667	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	7,581,041		7,581,041	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	817,028		817,028	0	0	52.00
53.00	ANESTHESIOLOGY	1,145,057		1,145,057	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,688,942		4,688,942	0	0	54.00
56.00	RADIOISOTOPE	911,122		911,122	0	0	56.00
60.00	LABORATORY	7,624,806		7,624,806	0	0	60.00
65.00	RESPIRATORY THERAPY	1,986,688	0	1,986,688	0	0	65.00
66.00	PHYSICAL THERAPY	2,948,711	0	2,948,711	0	0	66.00
69.00	ELECTROCARDIOLOGY	4,434,545		4,434,545	0	0	69.00
69.01	PULMONARY	117,660		117,660	0	0	69.01
69.02	CARDIOPULMONARY	224,938		224,938	0	0	69.02
69.03	SLEEP LAB	371,562		371,562	0	0	69.03
70.00	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,899,942		3,899,942	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	9,227,593		9,227,593	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	11,007,965		11,007,965	0	0	73.00
74.00	RENAL DIALYSIS	0		0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	422,121		422,121	0	0	88.00
88.01	LOOGOOTEE (RHC)	893,381		893,381	0	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	CLINIC	2,658,408		2,658,408	0	0	90.00
90.01	IMED	812,068		812,068	0	0	90.01
90.02	ONCOLOGY	3,208,351		3,208,351	0	0	90.02
91.00	EMERGENCY	6,068,709		6,068,709	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	975,457		975,457		0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	2,434,012		2,434,012	0	0	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
101.00	HOME HEALTH AGENCY	1,369,920		1,369,920		0	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	197,560		197,560		0	116.00
200.00	Subtotal (see instructions)	98,940,618	0	98,940,618	0	0	200.00
201.00	Less Observation Beds	975,457		975,457		0	201.00
202.00	Total (see instructions)	97,965,161	0	97,965,161	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 3/28/2012 1:31 pm

Title XIX | Hospital | Cost

	Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	15,205,274		15,205,274			30.00
31.00	INTENSIVE CARE UNIT	4,985,395		4,985,395			31.00
40.00	SUBPROVIDER - IPF	1,833,115		1,833,115			40.00
41.00	SUBPROVIDER - IRF	1,388,500		1,388,500			41.00
43.00	NURSERY	0		0			43.00
44.00	SKILLED NURSING FACILITY	1,148,365		1,148,365			44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	5,542,669	20,199,625	25,742,294	0.294497	0.000000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	1,153,824	283,926	1,437,750	0.568268	0.000000	52.00
53.00	ANESTHESIOLOGY	819,025	1,803,146	2,622,171	0.436683	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,885,936	26,728,499	31,614,435	0.148316	0.000000	54.00
56.00	RADIOISOTOPE	536,641	4,541,510	5,078,151	0.179420	0.000000	56.00
60.00	LABORATORY	6,212,348	15,488,401	21,700,749	0.351361	0.000000	60.00
65.00	RESPIRATORY THERAPY	1,648,405	1,261,898	2,910,303	0.682640	0.000000	65.00
66.00	PHYSICAL THERAPY	2,866,614	1,558,857	4,425,471	0.666304	0.000000	66.00
69.00	ELECTROCARDIOLOGY	7,176,942	9,822,359	16,999,301	0.260866	0.000000	69.00
69.01	PULMONARY	79,428	368,325	447,753	0.262779	0.000000	69.01
69.02	CARDIOPULMONARY	327	474,299	474,626	0.473927	0.000000	69.02
69.03	SLEEP LAB	1,766	955,550	957,316	0.388129	0.000000	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,018,889	4,248,763	9,267,652	0.420812	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	9,747,956	2,886,841	12,634,797	0.730332	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	24,917,634	26,108,850	51,026,484	0.215730	0.000000	73.00
74.00	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	0	439,425	439,425	0.960621	0.000000	88.00
88.01	LOOGOOTEE (RHC)	0	848,476	848,476	1.052924	0.000000	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	CLINIC	18,150	1,285,226	1,303,376	2.039632	0.000000	90.00
90.01	IMED	0	751,952	751,952	1.079947	0.000000	90.01
90.02	ONCOLOGY	196,251	7,610,497	7,806,748	0.410972	0.000000	90.02
91.00	EMERGENCY	2,244,911	7,935,950	10,180,861	0.596090	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	230,000	728,273	958,273	1.017932	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	749,870	1,361,828	2,111,698	1.152633	0.000000	95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
101.00	HOME HEALTH AGENCY	0	1,256,433	1,256,433			101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	0	0	0			116.00
200.00	Subtotal (see instructions)	98,608,235	138,948,909	237,557,144			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	98,608,235	138,948,909	237,557,144			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 150115	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 3/28/2012 1:31 pm
	Title XIX	Hospital	Cost

	Cost Center Description	PPS Inpatient Ratio 11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
40.00	SUBPROVIDER - IPF			40.00
41.00	SUBPROVIDER - IRF			41.00
43.00	NURSERY			43.00
44.00	SKILLED NURSING FACILITY			44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0.000000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	RADIOISOTOPE	0.000000		56.00
60.00	LABORATORY	0.000000		60.00
65.00	RESPIRATORY THERAPY	0.000000		65.00
66.00	PHYSICAL THERAPY	0.000000		66.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
69.01	PULMONARY	0.000000		69.01
69.02	CARDIOPULMONARY	0.000000		69.02
69.03	SLEEP LAB	0.000000		69.03
70.00	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	RENAL DIALYSIS	0.000000		74.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	FRENCH LICK (RHC)	0.000000		88.00
88.01	LOOGOOTEE (RHC)	0.000000		88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	CLINIC	0.000000		90.00
90.01	IMED	0.000000		90.01
90.02	ONCOLOGY	0.000000		90.02
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	0.000000		95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
101.00	HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
116.00	HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part I Date/Time Prepared: 3/28/2012 1:31 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,349,086	0	1,349,086	15,383	87.70	30.00
31.00	INTENSIVE CARE UNIT	500,165		500,165	5,286	94.62	31.00
40.00	SUBPROVIDER - IPF	155,068	0	155,068	2,172	71.39	40.00
41.00	SUBPROVIDER - IRF	190,730	0	190,730	1,632	116.87	41.00
43.00	NURSERY	0		0	1,766	0.00	43.00
44.00	SKILLED NURSING FACILITY	276,458		276,458	5,059	54.65	44.00
200.00	Total (lines 30-199)	2,471,507		2,471,507	31,298		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part I Date/Time Prepared: 3/28/2012 1:31 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	7,153	627,318		30.00
31.00	INTENSIVE CARE UNIT	3,293	311,584		31.00
40.00	SUBPROVIDER - IPF	925	66,036		40.00
41.00	SUBPROVIDER - IRF	1,149	134,284		41.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	4,108	224,502		44.00
200.00	Total (lines 30-199)	16,628	1,363,724		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part II Date/Time Prepared: 3/28/2012 1:31 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	822,863	25,742,294	0.031965	2,907,498	92,938	50.00
52.00	DELIVERY ROOM & LABOR ROOM	93,263	1,437,750	0.064867	2,000	130	52.00
53.00	ANESTHESIOLOGY	23,912	2,622,171	0.009119	288,968	2,635	53.00
54.00	RADIOLOGY-DIAGNOSTIC	434,073	31,614,435	0.013730	3,240,571	44,493	54.00
56.00	RADIOISOTOPE	49,684	5,078,151	0.009784	249,276	2,439	56.00
60.00	LABORATORY	296,112	21,700,749	0.013645	3,750,185	51,171	60.00
65.00	RESPIRATORY THERAPY	80,457	2,910,303	0.027646	756,001	20,900	65.00
66.00	PHYSICAL THERAPY	206,084	4,425,471	0.046568	850,168	39,591	66.00
69.00	ELECTROCARDIOLOGY	488,268	16,999,301	0.028723	3,164,493	90,894	69.00
69.01	PULMONARY	13,474	447,753	0.030092	35,022	1,054	69.01
69.02	CARDIOPULMONARY	35,532	474,626	0.074863	144	11	69.02
69.03	SLEEP LAB	52,618	957,316	0.054964	779	43	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,765	9,267,652	0.010765	2,514,984	27,074	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	162,835	12,634,797	0.012888	6,157,919	79,363	72.00
73.00	DRUGS CHARGED TO PATIENTS	304,386	51,026,484	0.005965	12,540,370	74,803	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	44,544	439,425	0.101369	0	0	88.00
88.01	LOOGOOTEE (RHC)	134,147	848,476	0.158103	0	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	964,251	1,303,376	0.739810	1,206	892	90.00
90.01	IMED	98,541	751,952	0.131047	0	0	90.01
90.02	ONCOLOGY	294,205	7,806,748	0.037686	13,046	492	90.02
91.00	EMERGENCY	395,234	10,180,861	0.038821	1,184,471	45,982	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	106,626	958,273	0.111269	225,337	25,073	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00	Total (lines 50-199)	5,200,874	209,628,364		37,882,438	599,978	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part III Date/Time Prepared: 3/28/2012 1:31 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	NURSERY	0	0	0		0	43.00
44.00	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00	Total (lines 30-199)	0	0	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part III Date/Time Prepared: 3/28/2012 1:31 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
		6.00	7.00	8.00	9.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	15,383	0.00	7,153	0		30.00
31.00	INTENSIVE CARE UNIT	5,286	0.00	3,293	0		31.00
40.00	SUBPROVIDER - IPF	2,172	0.00	925	0		40.00
41.00	SUBPROVIDER - IRF	1,632	0.00	1,149	0		41.00
43.00	NURSERY	1,766	0.00	0	0		43.00
44.00	SKILLED NURSING FACILITY	5,059	0.00	4,108	0		44.00
200.00	Total (lines 30-199)	31,298		16,628	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 3/28/2012 1:31 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	PULMONARY	0	0	0	0	0	69.01
69.02	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	SLEEP LAB	0	0	0	0	0	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	0	0	0	0	0	88.00
88.01	LOOGOOTEE (RHC)	0	0	0	0	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
90.01	IMED	0	0	0	0	0	90.01
90.02	ONCOLOGY	0	0	0	0	0	90.02
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 3/28/2012 1:31 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	25,742,294	0.000000	0.000000	2,907,498	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	1,437,750	0.000000	0.000000	2,000	52.00
53.00	ANESTHESIOLOGY	0	2,622,171	0.000000	0.000000	288,968	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	31,614,435	0.000000	0.000000	3,240,571	54.00
56.00	RADIOISOTOPE	0	5,078,151	0.000000	0.000000	249,276	56.00
60.00	LABORATORY	0	21,700,749	0.000000	0.000000	3,750,185	60.00
65.00	RESPIRATORY THERAPY	0	2,910,303	0.000000	0.000000	756,001	65.00
66.00	PHYSICAL THERAPY	0	4,425,471	0.000000	0.000000	850,168	66.00
69.00	ELECTROCARDIOLOGY	0	16,999,301	0.000000	0.000000	3,164,493	69.00
69.01	PULMONARY	0	447,753	0.000000	0.000000	35,022	69.01
69.02	CARDIOPULMONARY	0	474,626	0.000000	0.000000	144	69.02
69.03	SLEEP LAB	0	957,316	0.000000	0.000000	779	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,267,652	0.000000	0.000000	2,514,984	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	12,634,797	0.000000	0.000000	6,157,919	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	51,026,484	0.000000	0.000000	12,540,370	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	0	439,425	0.000000	0.000000	0	88.00
88.01	LOOGOOTEE (RHC)	0	848,476	0.000000	0.000000	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	CLINIC	0	1,303,376	0.000000	0.000000	1,206	90.00
90.01	IMED	0	751,952	0.000000	0.000000	0	90.01
90.02	ONCOLOGY	0	7,806,748	0.000000	0.000000	13,046	90.02
91.00	EMERGENCY	0	10,180,861	0.000000	0.000000	1,184,471	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	958,273	0.000000	0.000000	225,337	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	0	209,628,364			37,882,438	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 3/28/2012 1:31 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	5,592,458	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	451,623	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	11,732,706	0		54.00
56.00	RADIOISOTOPE	0	1,264,224	0		56.00
60.00	LABORATORY	0	841,142	0		60.00
65.00	RESPIRATORY THERAPY	0	27,795	0		65.00
66.00	PHYSICAL THERAPY	0	27,005	0		66.00
69.00	ELECTROCARDIOLOGY	0	2,343,526	0		69.00
69.01	PULMONARY	0	87,879	0		69.01
69.02	CARDIOPULMONARY	0	113,163	0		69.02
69.03	SLEEP LAB	0	227,986	0		69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,125,464	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	1,312,833	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	11,640,873	0		73.00
74.00	RENAL DIALYSIS	0	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	FRENCH LICK (RHC)	0	0	0		88.00
88.01	LOOGOOTEE (RHC)	0	0	0		88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	0	123,769	0		90.00
90.01	IMED	0	72,414	0		90.01
90.02	ONCOLOGY	0	732,901	0		90.02
91.00	EMERGENCY	0	1,515,240	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	380,252	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES					95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00	Total (lines 50-199)	0	39,613,253	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150115	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.294497	5,592,458	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.568268	0	0	0		52.00
53.00	ANESTHESIOLOGY	0.436683	451,623	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.148316	11,732,706	143	0		54.00
56.00	RADIOISOTOPE	0.179420	1,264,224	0	0		56.00
60.00	LABORATORY	0.351361	841,142	-245	0		60.00
65.00	RESPIRATORY THERAPY	0.682640	27,795	0	0		65.00
66.00	PHYSICAL THERAPY	0.666304	27,005	0	0		66.00
69.00	ELECTROCARDIOLOGY	0.260866	2,343,526	0	0		69.00
69.01	PULMONARY	0.262779	87,879	0	0		69.01
69.02	CARDIOPULMONARY	0.473927	113,163	0	0		69.02
69.03	SLEEP LAB	0.388129	227,986	0	0		69.03
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.420812	1,125,464	556	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.730332	1,312,833	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.215730	11,640,873	-449	4,714		73.00
74.00	RENAL DIALYSIS	0.000000	0	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	0.000000					88.00
88.01	LOOGOOTEE (RHC)	0.000000					88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	CLINIC	2.039632	123,769	0	0		90.00
90.01	IMED	1.079947	72,414	0	0		90.01
90.02	ONCOLOGY	0.410972	732,901	0	0		90.02
91.00	EMERGENCY	0.596090	1,515,240	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.017932	380,252	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	1.152633		0			95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0		96.00
200.00	Subtotal (see instructions)		39,613,253	5	4,714		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		39,613,253	5	4,714		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 3/28/2012 1:31 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Costs: PPS Services (see instructions)	Costs: Cost Services Subject To Ded. & Coins. (see instructions)	Costs: Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	1,646,962	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	197,216	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,740,148	21	0		54.00
56.00	RADIOISOTOPE	226,827	0	0		56.00
60.00	LABORATORY	295,544	-86	0		60.00
65.00	RESPIRATORY THERAPY	18,974	0	0		65.00
66.00	PHYSICAL THERAPY	17,994	0	0		66.00
69.00	ELECTROCARDIOLOGY	611,346	0	0		69.00
69.01	PULMONARY	23,093	0	0		69.01
69.02	CARDIOPULMONARY	53,631	0	0		69.02
69.03	SLEEP LAB	88,488	0	0		69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	473,609	234	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	958,804	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	2,511,286	-97	1,017		73.00
74.00	RENAL DIALYSIS	0	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	FRENCH LICK (RHC)	0	0	0		88.00
88.01	LOOGOOTEE (RHC)	0	0	0		88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	252,443	0	0		90.00
90.01	IMED	78,203	0	0		90.01
90.02	ONCOLOGY	301,202	0	0		90.02
91.00	EMERGENCY	903,219	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	387,071	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES		0			95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00	Subtotal (see instructions)	10,786,060	72	1,017		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	10,786,060	72	1,017		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150115
Component CCN: 15S115

Period: From 07/01/2010 To 06/30/2011

Worksheet D Part II
Date/Time Prepared: 3/28/2012 1:31 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	822,863	25,742,294	0.031965	386	12	50.00
52.00	DELIVERY ROOM & LABOR ROOM	93,263	1,437,750	0.064867	0	0	52.00
53.00	ANESTHESIOLOGY	23,912	2,622,171	0.009119	526	5	53.00
54.00	RADIOLOGY-DIAGNOSTIC	434,073	31,614,435	0.013730	40,422	555	54.00
56.00	RADIOISOTOPE	49,684	5,078,151	0.009784	0	0	56.00
60.00	LABORATORY	296,112	21,700,749	0.013645	88,348	1,206	60.00
65.00	RESPIRATORY THERAPY	80,457	2,910,303	0.027646	1,778	49	65.00
66.00	PHYSICAL THERAPY	206,084	4,425,471	0.046568	5,838	272	66.00
69.00	ELECTROCARDIOLOGY	488,268	16,999,301	0.028723	5,203	149	69.00
69.01	PULMONARY	13,474	447,753	0.030092	0	0	69.01
69.02	CARDIOPULMONARY	35,532	474,626	0.074863	0	0	69.02
69.03	SLEEP LAB	52,618	957,316	0.054964	0	0	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,765	9,267,652	0.010765	3,870	42	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	162,835	12,634,797	0.012888	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	304,386	51,026,484	0.005965	205,704	1,227	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	44,544	439,425	0.101369	0	0	88.00
88.01	LOOGOOTEE (RHC)	134,147	848,476	0.158103	0	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	964,251	1,303,376	0.739810	197	146	90.00
90.01	IMED	98,541	751,952	0.131047	0	0	90.01
90.02	ONCOLOGY	294,205	7,806,748	0.037686	0	0	90.02
91.00	EMERGENCY	395,234	10,180,861	0.038821	36,297	1,409	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	106,626	958,273	0.111269	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00	Total (lines 50-199)	5,200,874	209,628,364		388,569	5,072	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150115 Component CCN: 15S115	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	PULMONARY	0	0	0	0	0	69.01
69.02	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	SLEEP LAB	0	0	0	0	0	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	0	0	0	0	0	88.00
88.01	LOOGOOTEE (RHC)	0	0	0	0	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
90.01	IMED	0	0	0	0	0	90.01
90.02	ONCOLOGY	0	0	0	0	0	90.02
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 150115
Component CCN: 15S115

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part IV
Date/Time Prepared:
3/28/2012 1:31 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	25,742,294	0.000000	0.000000	386	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	1,437,750	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	2,622,171	0.000000	0.000000	526	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	31,614,435	0.000000	0.000000	40,422	54.00
56.00	RADIOISOTOPE	0	5,078,151	0.000000	0.000000	0	56.00
60.00	LABORATORY	0	21,700,749	0.000000	0.000000	88,348	60.00
65.00	RESPIRATORY THERAPY	0	2,910,303	0.000000	0.000000	1,778	65.00
66.00	PHYSICAL THERAPY	0	4,425,471	0.000000	0.000000	5,838	66.00
69.00	ELECTROCARDIOLOGY	0	16,999,301	0.000000	0.000000	5,203	69.00
69.01	PULMONARY	0	447,753	0.000000	0.000000	0	69.01
69.02	CARDIOPULMONARY	0	474,626	0.000000	0.000000	0	69.02
69.03	SLEEP LAB	0	957,316	0.000000	0.000000	0	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,267,652	0.000000	0.000000	3,870	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	12,634,797	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	51,026,484	0.000000	0.000000	205,704	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	0	439,425	0.000000	0.000000	0	88.00
88.01	LOOGOOTEE (RHC)	0	848,476	0.000000	0.000000	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	CLINIC	0	1,303,376	0.000000	0.000000	197	90.00
90.01	IMED	0	751,952	0.000000	0.000000	0	90.01
90.02	ONCOLOGY	0	7,806,748	0.000000	0.000000	0	90.02
91.00	EMERGENCY	0	10,180,861	0.000000	0.000000	36,297	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	958,273	0.000000	0.000000	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	0	209,628,364			388,569	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150115 Component CCN: 15S115	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	RADIOISOTOPE	0	0	0		56.00
60.00	LABORATORY	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	PULMONARY	0	0	0		69.01
69.02	CARDIOPULMONARY	0	0	0		69.02
69.03	SLEEP LAB	0	0	0		69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	RENAL DIALYSIS	0	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	FRENCH LICK (RHC)	0	0	0		88.00
88.01	LOOGOOTEE (RHC)	0	0	0		88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	0	0	0		90.00
90.01	IMED	0	0	0		90.01
90.02	ONCOLOGY	0	0	0		90.02
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES					95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150115
Component CCN: 15T115

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part II
Date/Time Prepared:
3/28/2012 1:31 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	822,863	25,742,294	0.031965	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	93,263	1,437,750	0.064867	0	0	52.00
53.00	ANESTHESIOLOGY	23,912	2,622,171	0.009119	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	434,073	31,614,435	0.013730	13,550	186	54.00
56.00	RADIOISOTOPE	49,684	5,078,151	0.009784	0	0	56.00
60.00	LABORATORY	296,112	21,700,749	0.013645	67,509	921	60.00
65.00	RESPIRATORY THERAPY	80,457	2,910,303	0.027646	18,507	512	65.00
66.00	PHYSICAL THERAPY	206,084	4,425,471	0.046568	512,674	23,874	66.00
69.00	ELECTROCARDIOLOGY	488,268	16,999,301	0.028723	2,782	80	69.00
69.01	PULMONARY	13,474	447,753	0.030092	0	0	69.01
69.02	CARDIOPULMONARY	35,532	474,626	0.074863	0	0	69.02
69.03	SLEEP LAB	52,618	957,316	0.054964	0	0	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,765	9,267,652	0.010765	28,062	302	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	162,835	12,634,797	0.012888	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	304,386	51,026,484	0.005965	452,628	2,700	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	44,544	439,425	0.101369	0	0	88.00
88.01	LOOGOOTEE (RHC)	134,147	848,476	0.158103	0	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	964,251	1,303,376	0.739810	0	0	90.00
90.01	IMED	98,541	751,952	0.131047	0	0	90.01
90.02	ONCOLOGY	294,205	7,806,748	0.037686	0	0	90.02
91.00	EMERGENCY	395,234	10,180,861	0.038821	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	106,626	958,273	0.111269	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00	Total (lines 50-199)	5,200,874	209,628,364		1,095,712	28,575	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150115 Component CCN: 15T115	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	PULMONARY	0	0	0	0	0	69.01
69.02	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	SLEEP LAB	0	0	0	0	0	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	0	0	0	0	0	88.00
88.01	LOOGOOTEE (RHC)	0	0	0	0	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
90.01	IMED	0	0	0	0	0	90.01
90.02	ONCOLOGY	0	0	0	0	0	90.02
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 150115
Component CCN: 15T115

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part IV
Date/Time Prepared:
3/28/2012 1:31 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	25,742,294	0.000000	0.000000	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	1,437,750	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	2,622,171	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	31,614,435	0.000000	0.000000	13,550	54.00
56.00	RADIOISOTOPE	0	5,078,151	0.000000	0.000000	0	56.00
60.00	LABORATORY	0	21,700,749	0.000000	0.000000	67,509	60.00
65.00	RESPIRATORY THERAPY	0	2,910,303	0.000000	0.000000	18,507	65.00
66.00	PHYSICAL THERAPY	0	4,425,471	0.000000	0.000000	512,674	66.00
69.00	ELECTROCARDIOLOGY	0	16,999,301	0.000000	0.000000	2,782	69.00
69.01	PULMONARY	0	447,753	0.000000	0.000000	0	69.01
69.02	CARDIOPULMONARY	0	474,626	0.000000	0.000000	0	69.02
69.03	SLEEP LAB	0	957,316	0.000000	0.000000	0	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,267,652	0.000000	0.000000	28,062	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	12,634,797	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	51,026,484	0.000000	0.000000	452,628	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	0	439,425	0.000000	0.000000	0	88.00
88.01	LOOGOOTEE (RHC)	0	848,476	0.000000	0.000000	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	CLINIC	0	1,303,376	0.000000	0.000000	0	90.00
90.01	IMED	0	751,952	0.000000	0.000000	0	90.01
90.02	ONCOLOGY	0	7,806,748	0.000000	0.000000	0	90.02
91.00	EMERGENCY	0	10,180,861	0.000000	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	958,273	0.000000	0.000000	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	0	209,628,364			1,095,712	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150115 Component CCN: 15T115	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	RADIOISOTOPE	0	0	0		56.00
60.00	LABORATORY	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	PULMONARY	0	0	0		69.01
69.02	CARDIOPULMONARY	0	0	0		69.02
69.03	SLEEP LAB	0	0	0		69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	RENAL DIALYSIS	0	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	FRENCH LICK (RHC)	0	0	0		88.00
88.01	LOOGOOTEE (RHC)	0	0	0		88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	0	0	0		90.00
90.01	IMED	0	0	0		90.01
90.02	ONCOLOGY	0	0	0		90.02
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES					95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150115
Component CCN: 155305

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part IV
Date/Time Prepared:
3/28/2012 1:31 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	PULMONARY	0	0	0	0	0	69.01
69.02	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	SLEEP LAB	0	0	0	0	0	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	0	0	0	0	0	88.00
88.01	LOOGOOTEE (RHC)	0	0	0	0	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
90.01	IMED	0	0	0	0	0	90.01
90.02	ONCOLOGY	0	0	0	0	0	90.02
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 150115
Component CCN: 155305

Period: From 07/01/2010 To 06/30/2011

Worksheet D Part IV
Date/Time Prepared: 3/28/2012 1:31 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	25,742,294	0.000000	0.000000	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	1,437,750	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	2,622,171	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	31,614,435	0.000000	0.000000	20,089	54.00
56.00	RADIOISOTOPE	0	5,078,151	0.000000	0.000000	0	56.00
60.00	LABORATORY	0	21,700,749	0.000000	0.000000	220,759	60.00
65.00	RESPIRATORY THERAPY	0	2,910,303	0.000000	0.000000	57,785	65.00
66.00	PHYSICAL THERAPY	0	4,425,471	0.000000	0.000000	768,791	66.00
69.00	ELECTROCARDIOLOGY	0	16,999,301	0.000000	0.000000	3,611	69.00
69.01	PULMONARY	0	447,753	0.000000	0.000000	0	69.01
69.02	CARDIOPULMONARY	0	474,626	0.000000	0.000000	0	69.02
69.03	SLEEP LAB	0	957,316	0.000000	0.000000	0	69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,267,652	0.000000	0.000000	110,109	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	12,634,797	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	51,026,484	0.000000	0.000000	1,671,227	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	0	439,425	0.000000	0.000000	0	88.00
88.01	LOOGOOTEE (RHC)	0	848,476	0.000000	0.000000	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	CLINIC	0	1,303,376	0.000000	0.000000	0	90.00
90.01	IMED	0	751,952	0.000000	0.000000	0	90.01
90.02	ONCOLOGY	0	7,806,748	0.000000	0.000000	0	90.02
91.00	EMERGENCY	0	10,180,861	0.000000	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	958,273	0.000000	0.000000	947	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	0	209,628,364			2,853,318	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	RADIOISOTOPE	0	0	0		56.00
60.00	LABORATORY	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	PULMONARY	0	0	0		69.01
69.02	CARDIOPULMONARY	0	0	0		69.02
69.03	SLEEP LAB	0	0	0		69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	RENAL DIALYSIS	0	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	FRENCH LICK (RHC)	0	0	0		88.00
88.01	LOOGOOTEE (RHC)	0	0	0		88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	0	0	0		90.00
90.01	IMED	0	0	0		90.01
90.02	ONCOLOGY	0	0	0		90.02
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES					95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 3/28/2012 1:31 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.294497	1,800,441	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.568268	145,524	0	0		52.00
53.00	ANESTHESIOLOGY	0.436683	635,932	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.148316	2,288,217	0	0		54.00
56.00	RADIOISOTOPE	0.179420	259,035	0	0		56.00
60.00	LABORATORY	0.351361	1,327,711	0	0		60.00
65.00	RESPIRATORY THERAPY	0.682640	68,772	0	0		65.00
66.00	PHYSICAL THERAPY	0.666304	171,447	0	0		66.00
69.00	ELECTROCARDIOLOGY	0.260866	669,776	0	0		69.00
69.01	PULMONARY	0.262779	30,394	0	0		69.01
69.02	CARDIOPULMONARY	0.473927	8,586	0	0		69.02
69.03	SLEEP LAB	0.388129	91,102	0	0		69.03
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.420812	45,001	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.730332	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.215730	2,227,159	0	0		73.00
74.00	RENAL DIALYSIS	0.000000	0	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	FRENCH LICK (RHC)	0.960621					88.00
88.01	LOOGOOTEE (RHC)	1.052924					88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	CLINIC	2.039632	85,697	0	0		90.00
90.01	IMED	1.079947	52	0	0		90.01
90.02	ONCOLOGY	0.410972	364,005	0	0		90.02
91.00	EMERGENCY	0.596090	1,424,273	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.017932	0	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	1.152633	175,951	0			95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0		96.00
200.00	Subtotal (see instructions)		11,643,124	0	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		11,643,124	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 3/28/2012 1:31 pm

Title XIX | Hospital | Cost

	Cost Center Description	Costs: PPS Services (see instructions)	Costs: Cost Services Subject To Ded. & Coins. (see instructions)	Costs: Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	530,224	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	82,697	0	0		52.00
53.00	ANESTHESIOLOGY	277,701	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	339,379	0	0		54.00
56.00	RADIOISOTOPE	46,476	0	0		56.00
60.00	LABORATORY	466,506	0	0		60.00
65.00	RESPIRATORY THERAPY	46,947	0	0		65.00
66.00	PHYSICAL THERAPY	114,236	0	0		66.00
69.00	ELECTROCARDIOLOGY	174,722	0	0		69.00
69.01	PULMONARY	7,987	0	0		69.01
69.02	CARDIOPULMONARY	4,069	0	0		69.02
69.03	SLEEP LAB	35,359	0	0		69.03
70.00	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,937	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	480,465	0	0		73.00
74.00	RENAL DIALYSIS	0	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	FRENCH LICK (RHC)	0	0	0		88.00
88.01	LOOGOOTEE (RHC)	0	0	0		88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	174,790	0	0		90.00
90.01	IMED	56	0	0		90.01
90.02	ONCOLOGY	149,596	0	0		90.02
91.00	EMERGENCY	848,995	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES		0			95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00	Subtotal (see instructions)	3,471,725	0	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	3,471,725	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,383	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,383	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)	15,383	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)	7,153	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	12,250,638	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)	12,250,638	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	20,190,752	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	20,190,752	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.606745	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)	1,312.54	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)	12,250,638	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)	796.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,696,506	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	5,696,506	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		Title XVIII			Hospital	PPS	
		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	4,877,277	5,286	922.68	3,293	3,038,385	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)	14,102,664	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	22,837,555	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)	938,902	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	599,978	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,538,880	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	21,298,675	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,193	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	796.38	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	950,081	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,349,086	12,250,638	0.110124	950,081	104,627	90.00
91.00	Nursing School cost	0	12,250,638	0.000000	950,081	0	91.00
92.00	Allied health cost	0	12,250,638	0.000000	950,081	0	92.00
93.00	All other Medical Education	0	12,250,638	0.000000	950,081	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115 Component CCN: 15S115	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,172	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,172	2.00
3.00	Private room days (excluding swing-bed and observation bed days)	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,172	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)	925	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,968,430	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,968,430	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,833,115	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,833,115	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.073817	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)	843.98	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,968,430	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)	906.28	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	838,309	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)	838,309	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115 Component CCN: 15S115	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description	1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	112,142	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	950,451	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)	66,036	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	5,072	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	71,108	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	879,343	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)	28	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	906.28	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	25,376	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115 Component CCN: 15S115	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	155,068	1,968,430	0.078778	25,376	1,999	90.00
91.00	Nursing School cost	0	1,968,430	0.000000	25,376	0	91.00
92.00	Allied health cost	0	1,968,430	0.000000	25,376	0	92.00
93.00	All other Medical Education	0	1,968,430	0.000000	25,376	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115 Component CCN: 15T115	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,632	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,632	2.00
3.00	Private room days (excluding swing-bed and observation bed days)	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,632	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,149	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,498,305	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,498,305	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,388,500	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,388,500	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.079082	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)	850.80	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,498,305	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)	918.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,054,874	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,054,874	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115 Component CCN: 15T115	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description	1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	490,358	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,545,232	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)	134,284	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	28,575	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	162,859	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,382,373	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115 Component CCN: 15T115	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	190,730	1,498,305	0.127297	0	0	90.00
91.00	Nursing School cost	0	1,498,305	0.000000	0	0	91.00
92.00	Allied health cost	0	1,498,305	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,498,305	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,059	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,059	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)	5,059	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,108	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,383,401	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,383,401	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,148,365	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,148,365	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	2.075473	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)	226.99	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,383,401	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,383,401	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	471.12	71.00
72.00	Program routine service cost (line 9 x line 71)	1,935,361	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,935,361	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,935,361	83.00
84.00	Program inpatient ancillary services (see instructions)	1,041,016	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,976,377	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	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: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	Title XIX Hospital Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,383	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,383	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)	15,383	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)	679	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)	1,766	15.00
16.00	Nursery days (title V or XIX only)	335	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	12,250,638	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)	12,250,638	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	20,190,752	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	20,190,752	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.606745	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)	1,312.54	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)	12,250,638	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)	796.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	540,742	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)	540,742	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		Title XIX			Hospital	Cost	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	1,766	0.00	335	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,877,277	5,286	922.68	141	130,098	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)	1,184,683	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,855,523	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,193	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	796.38	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	950,081	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm

Title XIX | Hospital | Cost

	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: 150115 Component CCN: 15S115	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,172	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,172	2.00
3.00	Private room days (excluding swing-bed and observation bed days)	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,172	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)	407	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)	1,766	15.00
16.00	Nursery days (title V or XIX only)	335	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,968,430	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,968,430	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,833,115	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,833,115	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.073817	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)	843.98	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,968,430	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)	906.28	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	368,856	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)	368,856	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150115
Component CCN: 15S115

Period: From 07/01/2010 To 06/30/2011

Worksheet D-1
Date/Time Prepared: 3/28/2012 1:31 pm

Title XIX | Subprovider - IPF | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description	1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	75,917	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	444,773	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)	28	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	906.28	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	25,376	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115 Component CCN: 15S115	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XIX	Subprovider - IPF	Cost

	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: 150115 Component CCN: 15T115	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,632	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,632	2.00
3.00	Private room days (excluding swing-bed and observation bed days)	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,632	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)	37	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)	1,766	15.00
16.00	Nursery days (title V or XIX only)	335	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,438,019	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,438,019	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,388,500	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,388,500	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.035664	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)	850.80	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,438,019	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)	881.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	32,602	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)	32,602	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115 Component CCN: 15T115	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description	1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	11,729	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	44,331	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115 Component CCN: 15T115	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XIX	Subprovider - IRF	Cost

	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: 150115 Component CCN: 155305	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XIX	Skilled Nursing Facility	

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,059	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,059	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)	5,059	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)	59	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)	1,766	15.00
16.00	Nursery days (title V or XIX only)	335	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,378,667	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,378,667	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,148,365	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,148,365	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	2.071351	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)	226.99	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,378,667	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XIX	Skilled Nursing Facility	

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,378,667	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	470.19	71.00
72.00	Program routine service cost (line 9 x line 71)	27,741	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	27,741	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	276,458	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	54.65	76.00
77.00	Program capital-related costs (line 9 x line 76)	3,224	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	24,517	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	24,517	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	3,224	83.00
84.00	Program inpatient ancillary services (see instructions)	0	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	3,224	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XIX	Skilled Nursing Facility	

	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: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-3 | Date/Time Prepared: 3/28/2012 1:31 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		5,613,552		30.00
31.00	INTENSIVE CARE UNIT		2,902,137		31.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.294497	2,907,498	856,249	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.568268	2,000	1,137	52.00
53.00	ANESTHESIOLOGY	0.436683	288,968	126,187	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.148316	3,240,571	480,629	54.00
56.00	RADIOISOTOPE	0.179420	249,276	44,725	56.00
60.00	LABORATORY	0.351361	3,750,185	1,317,669	60.00
65.00	RESPIRATORY THERAPY	0.687276	756,001	519,581	65.00
66.00	PHYSICAL THERAPY	0.666304	850,168	566,470	66.00
69.00	ELECTROCARDIOLOGY	0.308485	3,164,493	976,199	69.00
69.01	PULMONARY	0.262779	35,022	9,203	69.01
69.02	CARDIOPULMONARY	0.473927	144	68	69.02
69.03	SLEEP LAB	0.388129	779	302	69.03
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.420812	2,514,984	1,058,335	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.730332	6,157,919	4,497,325	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.215730	12,540,370	2,705,334	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	FRENCH LICK (RHC)	0.000000		0	88.00
88.01	LOOGOOTEE (RHC)	0.000000		0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	2.039632	1,206	2,460	90.00
90.01	IMED	1.079947	0	0	90.01
90.02	ONCOLOGY	0.410972	13,046	5,362	90.02
91.00	EMERGENCY	0.596090	1,184,471	706,051	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.017932	225,337	229,378	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		37,882,438	14,102,664	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		37,882,438		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150115 Component CCN: 15S115	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 3/28/2012 1:31 pm
Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
40.00	SUBPROVIDER - IPF		788,816		40.00
41.00	SUBPROVIDER - IRF		0		41.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.294497	386	114	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.568268	0	0	52.00
53.00	ANESTHESIOLOGY	0.436683	526	230	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.148316	40,422	5,995	54.00
56.00	RADIOISOTOPE	0.179420	0	0	56.00
60.00	LABORATORY	0.351361	88,348	31,042	60.00
65.00	RESPIRATORY THERAPY	0.687276	1,778	1,222	65.00
66.00	PHYSICAL THERAPY	0.666304	5,838	3,890	66.00
69.00	ELECTROCARDIOLOGY	0.308485	5,203	1,605	69.00
69.01	PULMONARY	0.262779	0	0	69.01
69.02	CARDIOPULMONARY	0.473927	0	0	69.02
69.03	SLEEP LAB	0.388129	0	0	69.03
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.420812	3,870	1,629	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.730332	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.215730	205,704	44,377	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	FRENCH LICK (RHC)	0.000000		0	88.00
88.01	LOOGOOTEE (RHC)	0.000000		0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	2.039632	197	402	90.00
90.01	IMED	1.079947	0	0	90.01
90.02	ONCOLOGY	0.410972	0	0	90.02
91.00	EMERGENCY	0.596090	36,297	21,636	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.017932	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		388,569	112,142	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		388,569		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150115
Component CCN: 15T115

Period: From 07/01/2010 To 06/30/2011

Worksheet D-3
Date/Time Prepared: 3/28/2012 1:31 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		976,536		41.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.294497	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.568268	0	0	52.00
53.00	ANESTHESIOLOGY	0.436683	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.148316	13,550	2,010	54.00
56.00	RADIOISOTOPE	0.179420	0	0	56.00
60.00	LABORATORY	0.351361	67,509	23,720	60.00
65.00	RESPIRATORY THERAPY	0.687276	18,507	12,719	65.00
66.00	PHYSICAL THERAPY	0.666304	512,674	341,597	66.00
69.00	ELECTROCARDIOLOGY	0.308485	2,782	858	69.00
69.01	PULMONARY	0.262779	0	0	69.01
69.02	CARDIOPULMONARY	0.473927	0	0	69.02
69.03	SLEEP LAB	0.388129	0	0	69.03
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.420812	28,062	11,809	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.730332	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.215730	452,628	97,645	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	FRENCH LICK (RHC)	0.000000		0	88.00
88.01	LOOGOOTEE (RHC)	0.000000		0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	2.039632	0	0	90.00
90.01	IMED	1.079947	0	0	90.01
90.02	ONCOLOGY	0.410972	0	0	90.02
91.00	EMERGENCY	0.596090	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.017932	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		1,095,712	490,358	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		1,095,712		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150115
Component CCN: 155305

Period:
From 07/01/2010
To 06/30/2011

Worksheet D-3
Date/Time Prepared:
3/28/2012 1:31 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.294497	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.568268	0	0	52.00
53.00	ANESTHESIOLOGY	0.436683	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.148316	20,089	2,980	54.00
56.00	RADIOISOTOPE	0.179420	0	0	56.00
60.00	LABORATORY	0.351361	220,759	77,566	60.00
65.00	RESPIRATORY THERAPY	0.682640	57,785	39,446	65.00
66.00	PHYSICAL THERAPY	0.666304	768,791	512,249	66.00
69.00	ELECTROCARDIOLOGY	0.260866	3,611	942	69.00
69.01	PULMONARY	0.262779	0	0	69.01
69.02	CARDIOPULMONARY	0.473927	0	0	69.02
69.03	SLEEP LAB	0.388129	0	0	69.03
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.420812	110,109	46,335	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.730332	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.215730	1,671,227	360,534	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	FRENCH LICK (RHC)	0.000000		0	88.00
88.01	LOOGOOTEE (RHC)	0.000000		0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	2.039632	0	0	90.00
90.01	IMED	1.079947	0	0	90.01
90.02	ONCOLOGY	0.410972	0	0	90.02
91.00	EMERGENCY	0.596090	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.017932	947	964	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		2,853,318	1,041,016	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		2,853,318		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-3 Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	Title XIX Ratio of Cost To Charges	Hospital Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		2,285,689		30.00
31.00	INTENSIVE CARE UNIT		304,318		31.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
43.00	NURSERY		0		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.294497	279,324	82,260	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.568268	34,902	19,834	52.00
53.00	ANESTHESIOLOGY	0.436683	88,080	38,463	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.148316	328,751	48,759	54.00
56.00	RADIOISOTOPE	0.179420	23,135	4,151	56.00
60.00	LABORATORY	0.351361	487,247	171,200	60.00
65.00	RESPIRATORY THERAPY	0.682640	194,681	132,897	65.00
66.00	PHYSICAL THERAPY	0.666304	30,247	20,154	66.00
69.00	ELECTROCARDIOLOGY	0.260866	437,122	114,030	69.00
69.01	PULMONARY	0.262779	7,542	1,982	69.01
69.02	CARDIOPULMONARY	0.473927	0	0	69.02
69.03	SLEEP LAB	0.388129	0	0	69.03
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.420812	44,369	18,671	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.730332	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.215730	1,891,696	408,096	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	FRENCH LICK (RHC)	0.960621	0	0	88.00
88.01	LOOGOOTEE (RHC)	1.052924	0	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	CLINIC	2.039632	2,917	5,950	90.00
90.01	IMED	1.079947	0	0	90.01
90.02	ONCOLOGY	0.410972	29,783	12,240	90.02
91.00	EMERGENCY	0.596090	177,818	105,996	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.017932	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		4,057,614	1,184,683	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		4,057,614		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150115
Component CCN: 15S115

Period:
From 07/01/2010
To 06/30/2011

Worksheet D-3
Date/Time Prepared:
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Title XIX | Subprovider - IPF | Cost

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
40.00	SUBPROVIDER - IPF		374,405		40.00
41.00	SUBPROVIDER - IRF		0		41.00
43.00	NURSERY		0		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.294497	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.568268	0	0	52.00
53.00	ANESTHESIOLOGY	0.436683	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.148316	7,135	1,058	54.00
56.00	RADIOISOTOPE	0.179420	0	0	56.00
60.00	LABORATORY	0.351361	60,432	21,233	60.00
65.00	RESPIRATORY THERAPY	0.682640	1,626	1,110	65.00
66.00	PHYSICAL THERAPY	0.666304	1,177	784	66.00
69.00	ELECTROCARDIOLOGY	0.260866	2,104	549	69.00
69.01	PULMONARY	0.262779	0	0	69.01
69.02	CARDIOPULMONARY	0.473927	0	0	69.02
69.03	SLEEP LAB	0.388129	0	0	69.03
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.420812	1,053	443	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.730332	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.215730	85,285	18,399	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	FRENCH LICK (RHC)	0.960621	0	0	88.00
88.01	LOOGOOTEE (RHC)	1.052924	0	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	CLINIC	2.039632	0	0	90.00
90.01	IMED	1.079947	0	0	90.01
90.02	ONCOLOGY	0.410972	0	0	90.02
91.00	EMERGENCY	0.596090	54,255	32,341	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.017932	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		213,067	75,917	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		213,067		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150115
Component CCN: 15T115

Period:
From 07/01/2010
To 06/30/2011

Worksheet D-3
Date/Time Prepared:
3/28/2012 1:31 pm

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		31,450		41.00
43.00	NURSERY		0		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.294497	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.568268	0	0	52.00
53.00	ANESTHESIOLOGY	0.436683	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.148316	414	61	54.00
56.00	RADIOISOTOPE	0.179420	0	0	56.00
60.00	LABORATORY	0.351361	912	320	60.00
65.00	RESPIRATORY THERAPY	0.682640	77	53	65.00
66.00	PHYSICAL THERAPY	0.666304	16,952	11,295	66.00
69.00	ELECTROCARDIOLOGY	0.260866	0	0	69.00
69.01	PULMONARY	0.262779	0	0	69.01
69.02	CARDIOPULMONARY	0.473927	0	0	69.02
69.03	SLEEP LAB	0.388129	0	0	69.03
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.420812	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.730332	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.215730	0	0	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	FRENCH LICK (RHC)	0.960621	0	0	88.00
88.01	LOOGOOTEE (RHC)	1.052924	0	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	CLINIC	2.039632	0	0	90.00
90.01	IMED	1.079947	0	0	90.01
90.02	ONCOLOGY	0.410972	0	0	90.02
91.00	EMERGENCY	0.596090	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.017932	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		18,355	11,729	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		18,355		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150115
Component CCN: 155305

Period:
From 07/01/2010
To 06/30/2011

Worksheet D-3
Date/Time Prepared:
3/28/2012 1:31 pm

Title XIX

Skilled Nursing Facility

	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		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
43.00	NURSERY		0		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.294497	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.568268	0	0	52.00
53.00	ANESTHESIOLOGY	0.436683	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.148316	0	0	54.00
56.00	RADIOISOTOPE	0.179420	0	0	56.00
60.00	LABORATORY	0.351361	0	0	60.00
65.00	RESPIRATORY THERAPY	0.682640	0	0	65.00
66.00	PHYSICAL THERAPY	0.666304	0	0	66.00
69.00	ELECTROCARDIOLOGY	0.260866	0	0	69.00
69.01	PULMONARY	0.262779	0	0	69.01
69.02	CARDIOPULMONARY	0.473927	0	0	69.02
69.03	SLEEP LAB	0.388129	0	0	69.03
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.420812	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.730332	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.215730	0	0	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	FRENCH LICK (RHC)	0.960621	0	0	88.00
88.01	LOOGOOTEE (RHC)	1.052924	0	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	CLINIC	2.039632	0	0	90.00
90.01	IMED	1.079947	0	0	90.01
90.02	ONCOLOGY	0.410972	0	0	90.02
91.00	EMERGENCY	0.596090	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.017932	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet E Part A Date/Time Prepared: 3/28/2012 1:31 pm

		Title XVIII	Hospital	PPS	
			before 1/1	on/after 1/1	
			1.00	1.01	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		20,759,534		1.00
2.00	Outlier payments for discharges. (see instructions)		74,067		2.00
3.00	Managed Care Simulated Payments		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		107.73		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment. (see instructions)		0.000000		27.00
28.00	IME Adjustment (see instructions)		0		28.00
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.96		30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		14.27		31.00
32.00	Sum of lines 30 and 31		17.23		32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.95		33.00
34.00	Disproportionate share adjustment (see instructions)		820,002		34.00
	Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0		46.00
47.00	Subtotal (see instructions)		21,653,603		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		21,653,603		49.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150115	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part A Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Hospital	PPS

		before 1/1	on/after 1/1	
		1.00	1.01	
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	1,677,227		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)	0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).	0		52.00
53.00	Nursing and Allied Health Managed Care payment	0		53.00
54.00	Special add-on payments for new technologies	0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)	0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)	0		56.00
57.00	Routine service other pass through costs	0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	0		58.00
59.00	Total (sum of amounts on lines 49 through 58)	23,330,830		59.00
60.00	Primary payer payments	12,209		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	23,318,621		61.00
62.00	Deductibles billed to program beneficiaries	2,440,138		62.00
63.00	Coinsurance billed to program beneficiaries	7,812		63.00
64.00	Allowable bad debts (see instructions)	246,365		64.00
65.00	Adjusted reimbursable bad debts (see instructions)	172,456		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	249,445		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	21,043,127		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)	0		68.00
69.00	Outlier payments reconciliation	0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		70.00
70.95	Recovery of Accelerated Depreciation	0		70.95
70.96	Low Volume Payment-1	0		70.96
70.97	Low Volume Payment-2	0		70.97
70.98	Low Volume Payment-3	0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	21,043,127		71.00
72.00	Interim payments	21,467,183		72.00
73.00	Tentative settlement (for contractor use only)	0		73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)	-424,056		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	155,697		75.00
	TO BE COMPLETED BY CONTRACTOR			
90.00	Operating outlier amount from Worksheet E, Part A line 2	0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2	0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)	0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)	0		93.00
94.00	The rate used to calculate the Time Value of Money	0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)	0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)	0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150115	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,089	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	10,786,060	2.00
3.00	PPS payments	12,533,409	3.00
4.00	Outlier payment (see instructions)	2,613	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)	1,089	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	4,719	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)	4,719	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 chargebasis 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)	4,719	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	3,630	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	1,089	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)	12,536,022	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	111	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,999,519	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)	9,537,481	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)	9,537,481	30.00
31.00	Primary payer payments	3,979	31.00
32.00	Subtotal (line 30 minus line 31)	9,533,502	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)	289,351	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	202,546	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	253,934	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	9,736,048	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-159	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)	9,736,207	40.00
41.00	Interim payments	9,540,047	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)	196,160	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150115 Component CCN: 15S115	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	0	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	0	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	0	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	0	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	0	40.00
41.00	Interim payments	0	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150115 Component CCN: 15T115	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	0	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	0	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	0	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	0	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	0	40.00
41.00	Interim payments	0	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	0	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	0	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	0	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	0	40.00
41.00	Interim payments	0	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet E-1 Part I Date/Time Prepared: 3/28/2012 1:31 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		21,283,574		9,533,131	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	02/03/2011	183,609	02/03/2011	6,916	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		183,609		6,916	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)		21,467,183		9,540,047	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		196,160	6.01
6.02	SETTLEMENT TO PROGRAM		424,056		0	6.02
7.00	Total Medicare program liability (see instructions)		21,043,127		9,736,207	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 150115 Component CCN: 15S115	Period: From 07/01/2010 To 06/30/2011	Worksheet E-1 Part I Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Subprovider - IPF	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		633,386		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		633,386		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		4,642		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		638,028		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 150115 Component CCN: 15T115	Period: From 07/01/2010 To 06/30/2011	Worksheet E-1 Part I Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Subprovider - IRF	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,494,889		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,494,889		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		11,405		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,506,294		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150115 Component CCN:	Period: From 07/01/2010 To 06/30/2011	Worksheet E-1 Part I Date/Time Prepared: 3/28/2012 1:31 pm
Title XVIII	Swing Beds - SNF	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		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2010 To 06/30/2011	Worksheet E-1 Part I Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Skilled Nursing Facility	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,492,768		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,492,768		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		3,506		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,496,274		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 150115 Component CCN:	Period: From 07/01/2010 To 06/30/2011	Worksheet E-2 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Swing Beds - SNF	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150115 Component CCN: 15S115	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part II Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	733,292	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	5.873973	9.00
10.00	Medical Education Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	733,292	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition	0	14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	15.00
16.00	Subtotal (see instructions)	733,292	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	733,292	18.00
19.00	Deductibles	91,416	19.00
20.00	Subtotal (line 18 minus line 19)	641,876	20.00
21.00	Coinsurance	8,490	21.00
22.00	Subtotal (line 20 minus line 21)	633,386	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	6,632	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	4,642	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,300	25.00
26.00	Subtotal (sum of lines 22 and 24)	638,028	26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	638,028	31.00
32.00	Interim payments	633,386	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)	4,642	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150115 Component CCN: 15T115	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part III Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	1,467,978	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0231	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	26,971	3.00
4.00	Outlier Payments	33,254	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	4.471233	10.00
11.00	Medical Education Adjustment Factor {((1 + (line 9/line 10)) raised to the power of .6876 -1}.	0.000000	11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).	0	12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)	1,528,203	13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)	0	14.00
15.00	Organ acquisition	0	15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	16.00
17.00	Subtotal (see instructions)	1,528,203	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	1,528,203	19.00
20.00	Deductibles	16,532	20.00
21.00	Subtotal (line 19 minus line 20)	1,511,671	21.00
22.00	Coinsurance	5,377	22.00
23.00	Subtotal (line 21 minus line 22)	1,506,294	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	1,506,294	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	1,506,294	32.00
33.00	Interim payments	1,494,889	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus the sum lines 33 and 34)	11,405	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part III, line 4	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part VI Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,596,092	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,596,092	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	103,324	7.00
8.00	Allowable bad debts (see instructions)	3,506	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	3,506	9.00
10.00	Allowable reimbursable bad debts (see instructions)	3,506	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	1,496,274	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	1,496,274	15.00
16.00	Interim payments	1,492,768	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)	3,506	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

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

Provider CCN: 150115

Period: From 07/01/2010 To 06/30/2011

Worksheet G

Date/Time Prepared: 3/28/2012 1:31 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURENT ASSETS					
1.00	Cash on hand in banks	44,499,509	0	0	0	1.00
2.00	Temporary investments	1,245,544	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	18,102,387	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	5,168,529	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)	69,015,969	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	5,907,661	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	104,492,366	0	0	0	15.00
16.00	Accumulated depreciation	-42,569,443	0	0	0	16.00
17.00	Leasehold improvements	364,190	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	62,408,771	0	0	0	19.00
20.00	Accumulated depreciation	-42,788,144	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	87,815,401	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	50,987,745	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	2,086,073	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	53,073,818	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	209,905,188	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,634,686	0	0	0	37.00
38.00	Salaries, wages, and fees payable	17,772,849	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,520,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	3,397,123				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	25,324,658	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	50,784,666	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	50,784,666	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	76,109,324	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	133,795,864				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)	133,795,864	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	209,905,188	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-1 | Date/Time Prepared: 3/28/2012 1:31 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		117,494,526		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7,119,542				2.00
3.00	Total (sum of line 1 and line 2)		124,614,068		0		3.00
4.00	STET	301,255		0			4.00
5.00	STET	3,586,517		0			5.00
6.00	PENSION	5,533,022		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)		9,420,794		0		10.00
11.00	Subtotal (line 3 plus line 10)		134,034,862		0		11.00
12.00	OTHER	238,998		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)		238,998		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		133,795,864		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-1 | Date/Time Prepared: 3/28/2012 1:31 pm

		Endowment Fund		Plant Fund			
		5.00	6.00	7.00	8.00		
1.00	Fund balances at beginning of period		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)		0		0		3.00
4.00	STET	0		0			4.00
5.00	STET	0		0			5.00
6.00	PENSION	0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		0		0		11.00
12.00	OTHER	0		0			12.00
13.00		0		0			13.00
14.00		0		0			14.00
15.00		0		0			15.00
16.00		0		0			16.00
17.00		0		0			17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 150115 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-2 Parts | Date/Time Prepared: 3/28/2012 1:31 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	26,311,779		26,311,779	1.00
2.00	SUBPROVIDER - IPF	1,388,500		1,388,500	2.00
3.00	SUBPROVIDER - IRF	1,857,329		1,857,329	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	1,151,340		1,151,340	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)	30,708,948		30,708,948	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	5,201,671		5,201,671	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)	5,201,671		5,201,671	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	35,910,619		35,910,619	17.00
18.00	Ancillary services	77,635,904	140,144,326	217,780,230	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	FRENCH LICK (RHC)	0	0	0	20.00
20.01	LOOGOOTEE (RHC)	0	0	0	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	749,870	1,361,828	2,111,698	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	20,650,178	0	20,650,178	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	134,946,571	141,506,154	276,452,725	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		145,015,972		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		145,015,972		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150115	Period: From 07/01/2010 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 3/28/2012 1:31 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	276,452,725	1.00
2.00	Less contractual allowances and discounts on patients' accounts	132,911,505	2.00
3.00	Net patient revenues (line 1 minus line 2)	143,541,220	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	145,015,972	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,474,752	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	4,883,377	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	737	13.00
14.00	Revenue from meals sold to employees and guests	496,370	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	228,330	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	5,792	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	2,979,688	24.00
25.00	Total other income (sum of lines 6-24)	8,594,294	25.00
26.00	Total (line 5 plus line 25)	7,119,542	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	7,119,542	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150115
HHA CCN: 157222

Period:
From 07/01/2010
To 06/30/2011

Worksheet H
Date/Time Prepared:
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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures			0		0	1.00
2.00	Capital Related - Movable Equipment			0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	281,934	0	0	39,016	42,707	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	275,282	0	31,299	0	0	6.00
7.00	Physical Therapy	78,221	0	14,224	0	0	7.00
8.00	Occupational Therapy	27,736	0	4,071	0	0	8.00
9.00	Speech Pathology	2,112	0	239	0	0	9.00
10.00	Medical Social Services	350	0	8	0	0	10.00
11.00	Home Health Aide	64,874	0	20,083	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)	730,509	0	69,924	39,016	42,707	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150115
HHA CCN: 157222

Period:
From 07/01/2010
To 06/30/2011

Worksheet H
Date/Time Prepared:
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		Total (sum of cols. 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	363,657	0	363,657	-175	363,482	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	306,581	0	306,581	0	306,581	6.00
7.00	Physical Therapy	92,445	0	92,445	0	92,445	7.00
8.00	Occupational Therapy	31,807	0	31,807	0	31,807	8.00
9.00	Speech Pathology	2,351	0	2,351	0	2,351	9.00
10.00	Medical Social Services	358	0	358	0	358	10.00
11.00	Home Health Aide	84,957	0	84,957	0	84,957	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)	882,156	0	882,156	-175	881,981	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.
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COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 150115
HHA CCN: 157222

Period:
From 07/01/2010
To 06/30/2011

Worksheet H-1
Part I
Date/Time Prepared:
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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0				1.00
2.00	Capital Related - Movable Equipment	0		0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	363,482	0	0	0	0	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	306,581	0	0	0	0	6.00
7.00	Physical Therapy	92,445	0	0	0	0	7.00
8.00	Occupational Therapy	31,807	0	0	0	0	8.00
9.00	Speech Pathology	2,351	0	0	0	0	9.00
10.00	Medical Social Services	358	0	0	0	0	10.00
11.00	Home Health Aide	84,957	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		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)	881,981	0	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 150115
HHA CCN: 157222

Period:
From 07/01/2010
To 06/30/2011

Worksheet H-1
Part I
Date/Time Prepared:
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		Subtotal (cols. 0-4)	Administrative & General	Total (cols. 4A + 5)		
		4A.00	5.00	6.00		
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0				1.00
2.00	Capital Related - Movable Equipment	0				2.00
3.00	Plant Operation & Maintenance	0				3.00
4.00	Transportation					4.00
5.00	Administrative and General	363,482	363,482			5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	306,581	214,922	521,503		6.00
7.00	Physical Therapy	92,445	64,806	157,251		7.00
8.00	Occupational Therapy	31,807	22,298	54,105		8.00
9.00	Speech Pathology	2,351	1,648	3,999		9.00
10.00	Medical Social Services	358	251	609		10.00
11.00	Home Health Aide	84,957	59,557	144,514		11.00
12.00	Supplies (see instructions)	0	0	0		12.00
13.00	Drugs	0	0	0		13.00
14.00	DME	0	0	0		14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0		17.00
18.00	Clinic	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0		19.00
20.00	Day Care Program	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0		21.00
22.00	Homemaker Service	0	0	0		22.00
23.00	All Others (specify)	0	0	0		23.00
24.00	Total (sum of lines 1-23)	518,499		881,981		24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 150115
HHA CCN: 157222

Period:
From 07/01/2010
To 06/30/2011

Worksheet H-1
Part II
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		Capital Related Costs					
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		1.00	2.00	3.00	4.00	5A.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-363,482	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	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	-363,482	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: 150115
HHA CCN: 157222

Period:
From 07/01/2010
To 06/30/2011

Worksheet H-1
Part II
Date/Time Prepared:
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		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	518,499		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	306,581		6.00
7.00	Physical Therapy	92,445		7.00
8.00	Occupational Therapy	31,807		8.00
9.00	Speech Pathology	2,351		9.00
10.00	Medical Social Services	358		10.00
11.00	Home Health Aide	84,957		11.00
12.00	Supplies (see instructions)	0		12.00
13.00	Drugs	0		13.00
14.00	DME	0		14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0		15.00
16.00	Respiratory Therapy	0		16.00
17.00	Private Duty Nursing	0		17.00
18.00	Clinic	0		18.00
19.00	Health Promotion Activities	0		19.00
20.00	Day Care Program	0		20.00
21.00	Home Delivered Meals Program	0		21.00
22.00	Homemaker Service	0		22.00
23.00	All Others (specify)	0		23.00
24.00	Total (sum of lines 1-23)	518,499		24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	363,482		25.00
26.00	Unit Cost Multiplier	0.701027		26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150115
HHA CCN: 157222

Period:
From 07/01/2010
To 06/30/2011

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

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		HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		0	1.00	2.00	4.00	4A	
1.00	Administrative and General	0	18,831	22,063	69,826	110,720	1.00
2.00	Skilled Nursing Care	521,503	0	0	69,049	590,552	2.00
3.00	Physical Therapy	157,251	0	0	19,620	176,871	3.00
4.00	Occupational Therapy	54,105	0	0	6,957	61,062	4.00
5.00	Speech Pathology	3,999	0	0	530	4,529	5.00
6.00	Medical Social Services	609	0	0	88	697	6.00
7.00	Home Health Aide	144,514	0	0	16,272	160,786	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)	881,981	18,831	22,063	182,342	1,105,217	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: 150115
HHA CCN: 157222

Period:
From 07/01/2010
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		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
1.00	Administrative and General	18,340	46,196	0	8,889	0	1.00
2.00	Skilled Nursing Care	97,819	0	0	0	0	2.00
3.00	Physical Therapy	29,297	0	0	0	0	3.00
4.00	Occupational Therapy	10,114	0	0	0	0	4.00
5.00	Speech Pathology	750	0	0	0	0	5.00
6.00	Medical Social Services	115	0	0	0	0	6.00
7.00	Home Health Aide	26,632	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)	183,067	46,196	0	8,889	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150115
HHA CCN: 157222

Period:
From 07/01/2010
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		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	6,268	0	0	727	0	1.00
2.00	Skilled Nursing Care	6,253	0	0	0	3,482	2.00
3.00	Physical Therapy	1,874	0	0	0	1,582	3.00
4.00	Occupational Therapy	609	0	0	0	453	4.00
5.00	Speech Pathology	45	0	0	0	27	5.00
6.00	Medical Social Services	13	0	0	0	1	6.00
7.00	Home Health Aide	2,983	0	0	0	2,234	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)	18,045	0	0	727	7,779	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: 150115
HHA CCN: 157222

Period:
From 07/01/2010
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Part I
Date/Time Prepared:
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		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	191,140	0	191,140			1.00
2.00	Skilled Nursing Care	698,106	0	698,106	113,198	811,304	2.00
3.00	Physical Therapy	209,624	0	209,624	33,991	243,615	3.00
4.00	Occupational Therapy	72,238	0	72,238	11,713	83,951	4.00
5.00	Speech Pathology	5,351	0	5,351	868	6,219	5.00
6.00	Medical Social Services	826	0	826	134	960	6.00
7.00	Home Health Aide	192,635	0	192,635	31,236	223,871	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	1,369,920	0	1,369,920	191,140	1,369,920	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.				0.162151		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: 150115
HHA CCN: 157222

Period:
From 07/01/2010
To 06/30/2011

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Part II
Date/Time Prepared:
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		CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
1.00	Administrative and General	2,579	2,579	279,741	0	110,720	1.00
2.00	Skilled Nursing Care	0	0	276,628	0	590,552	2.00
3.00	Physical Therapy	0	0	78,603	0	176,871	3.00
4.00	Occupational Therapy	0	0	27,872	0	61,062	4.00
5.00	Speech Pathology	0	0	2,122	0	4,529	5.00
6.00	Medical Social Services	0	0	352	0	697	6.00
7.00	Home Health Aide	0	0	65,191	0	160,786	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)	2,579	2,579	730,509		1,105,217	20.00
21.00	Total cost to be allocated	18,831	22,063	182,342		183,067	21.00
22.00	Unit cost multiplier	7.301667	8.554866	0.249610		0.165639	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150115
HHA CCN: 157222

Period:
From 07/01/2010
To 06/30/2011

Worksheet H-2
Part II
Date/Time Prepared:
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		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
		6.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	2,579	0	2,579	0	10,216	1.00
2.00	Skilled Nursing Care	0	0	0	0	10,191	2.00
3.00	Physical Therapy	0	0	0	0	3,055	3.00
4.00	Occupational Therapy	0	0	0	0	992	4.00
5.00	Speech Pathology	0	0	0	0	73	5.00
6.00	Medical Social Services	0	0	0	0	22	6.00
7.00	Home Health Aide	0	0	0	0	4,862	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)	2,579	0	2,579	0	29,411	20.00
21.00	Total cost to be allocated	46,196	0	8,889	0	18,045	21.00
22.00	Unit cost multiplier	17.912369	0.000000	3.446685	0.000000	0.613546	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150115
HHA CCN: 157222

Period:
From 07/01/2010
To 06/30/2011

Worksheet H-2
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		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)		
		13.00	14.00	15.00	16.00		
1.00	Administrative and General	0	0	511	0		1.00
2.00	Skilled Nursing Care	0	0	0	562,384		2.00
3.00	Physical Therapy	0	0	0	255,589		3.00
4.00	Occupational Therapy	0	0	0	73,148		4.00
5.00	Speech Pathology	0	0	0	4,303		5.00
6.00	Medical Social Services	0	0	0	143		6.00
7.00	Home Health Aide	0	0	0	360,866		7.00
8.00	Supplies (see instructions)	0	0	0	0		8.00
9.00	Drugs	0	0	0	0		9.00
10.00	DME	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0		13.00
14.00	Clinic	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0		19.00
20.00	Total (sum of lines 1-19)	0	0	511	1,256,433		20.00
21.00	Total cost to be allocated	0	0	727	7,779		21.00
22.00	Unit cost multiplier	0.000000	0.000000	1.422701	0.006191		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150115
HHA CCN: 157222

Period:
From 07/01/2010
To 06/30/2011

Worksheet H-3
Parts I-II
Date/Time Prepared:
3/28/2012 1:31 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	2.00	811,304		811,304	3,917	1.00
2.00	Physical Therapy	3.00	243,615	0	243,615	1,782	2.00
3.00	Occupational Therapy	4.00	83,951	0	83,951	510	3.00
4.00	Speech Pathology	5.00	6,219	0	6,219	31	4.00
5.00	Medical Social Services	6.00	960		960	4	5.00
6.00	Home Health Aide	7.00	223,871		223,871	2,516	6.00
7.00	Total (sum of lines 1-6)		1,369,920	0	1,369,920	8,760	7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B: Not Subject to Deductibles & Coinsurance	Program Visits Part B: Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
	Limitation Cost Computation						
8.00	Skilled Nursing Care		99915	1,180	867		8.00
9.00	Physical Therapy		99915	912	456		9.00
10.00	Occupational Therapy		99915	237	172		10.00
11.00	Speech Pathology		99915	11	20		11.00
12.00	Medical Social Services		99915	0	0		12.00
13.00	Home Health Aide		99915	599	462		13.00
14.00	Total (sum of lines 8-13)			2,939	1,977		14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
	Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	8.00	0	0	0	16,990	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	
		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	0.666304	0	0	1.00
2.00	Occupational Therapy					2.00
3.00	Speech Pathology					3.00
4.00	Cost of Medical Supplies	71.00	0.420812	0	0	4.00
5.00	Cost of Drugs	73.00	0.215730	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150115
HHA CCN: 157222

Period: From 07/01/2010 To 06/30/2011

Worksheet H-3 Parts I-II
Date/Time Prepared: 3/28/2012 1:31 pm

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	Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B 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	207.12	1,180	867			1.00
2.00	Physical Therapy	136.71	912	456			2.00
3.00	Occupational Therapy	164.61	237	172			3.00
4.00	Speech Pathology	200.61	11	20			4.00
5.00	Medical Social Services	240.00	0	0			5.00
6.00	Home Health Aide	88.98	599	462			6.00
7.00	Total (sum of lines 1-6)		2,939	1,977			7.00
	Cost Center Description						
		5.00	6.00	7.00	8.00	9.00	
	Limitation Cost Computation						
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00

	Cost Center Description	Ratio (col. 3 ÷ col. 4)	Program Covered Charges: Part A	Program Covered Charges: Part B Not Subject to Deductibles & Coinsurance	Program Covered Charges: Part B 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	7,057	19,418	0		15.00
16.00	Cost of Drugs	0.000000	0	0	0		16.00

	Cost Center Description	Transfer to Part I as Indicated			
		4.00			
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS				
1.00	Physical Therapy	col. 2, line 2.00			1.00
2.00	Occupational Therapy				2.00
3.00	Speech Pathology				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: 150115 HHA CCN: 157222	Period: From 07/01/2010 To 06/30/2011	Worksheet H-3 Parts I-II Date/Time Prepared: 3/28/2012 1:31 pm
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	Cost Center Description	Cost of Services: Part A	Cost of Services: Part B: Not Subject to Deductibles & Coinsurance	Cost of Services: Part B: Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols. 9-10)		
		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	244,402	179,573		423,975		1.00
2.00	Physical Therapy	124,680	62,340		187,020		2.00
3.00	Occupational Therapy	39,013	28,313		67,326		3.00
4.00	Speech Pathology	2,207	4,012		6,219		4.00
5.00	Medical Social Services	0	0		0		5.00
6.00	Home Health Aide	53,299	41,109		94,408		6.00
7.00	Total (sum of lines 1-6)	463,601	315,347		778,948		7.00

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

	Cost Center Description	Cost of Services: Part A	Cost of Services: Part B: Not Subject to Deductibles & Coinsurance	Cost of Services: Part B: Subject to Deductibles & Coinsurance		
		9.00	10.00	11.00		
	Supplies and Drugs Cost Computations					
15.00	Cost of Medical Supplies	0	0	0		15.00
16.00	Cost of Drugs	0	0	0		16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 150115 HHA CCN: 157222	Period: From 07/01/2010 To 06/30/2011	Worksheet H-4 Part I-II Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Home Health Agency I	PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B 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	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	422,809	270,825	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	1,927	2,190	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	8,603	4,309	13.00
14.00	Total PPS Reimbursement - PEP Episodes	6,351	5,300	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	131	723	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	439,821	283,347	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	439,821	283,347	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	439,821	283,347	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	439,821	283,347	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	439,821	283,347	31.00
32.00	Interim payments (see instructions)	439,821	283,347	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	35.00

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

Provider CCN: 150115
HHA CCN: 157222

Period: From 07/01/2010 To 06/30/2011

Worksheet H-5
Date/Time Prepared: 3/28/2012 1:31 pm

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		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		439,821		283,347	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)		439,821		283,347	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		439,821		283,347	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: 150115
Hospice CCN:

Period:
From 07/01/2010
To 06/30/2011

Worksheet K
Date/Time Prepared:
3/28/2012 1:31 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	9,027	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	97,711	0	0	0	3,729	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	Total (sum of lines 1 thru 38)	97,711	0	9,027	0	3,729	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150115
Hospice CCN:

Period:
From 07/01/2010
To 06/30/2011

Worksheet K
Date/Time Prepared:
3/28/2012 1:31 pm

Hospice I

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	9,027	0	9,027	0	9,027	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	101,440	0	101,440	0	101,440	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	Total (sum of lines 1 thru 38)	110,467	0	110,467	0	110,467	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150115
Hospice CCN:

Period:
From 07/01/2010
To 06/30/2011

Worksheet K-1
Date/Time Prepared:
3/28/2012 1:31 pm

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	97,711	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	97,711	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150115
Hospice CCN:

Period:
From 07/01/2010
To 06/30/2011

Worksheet K-1
Date/Time Prepared:
3/28/2012 1:31 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	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	0	97,711		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	97,711		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150115
Hospice CCN:

Period:
From 07/01/2010
To 06/30/2011

Worksheet K-4
Part I
Date/Time Prepared:
3/28/2012 1:31 pm

Hospice I

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00	2.00	3.00	4.00	
	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	9,027	0	0	0	9,027	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	101,440	0	0	0	9,027	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	Total (sum of lines 1 thru 38)	110,467	0	0	0	9,027	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150115
Hospice CCN:

Period:
From 07/01/2010
To 06/30/2011

Worksheet K-4
Part I
Date/Time Prepared:
3/28/2012 1:31 pm

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.		0				1.00
2.00	Capital Related Costs-Movable Equip.		0				2.00
3.00	Plant Operation and Maintenance		0				3.00
4.00	Transportation - Staff		0				4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	0				6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0		7.00
8.00	Inpatient - Respite Care	0	0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0		9.00
10.00	Nursing Care	0	110,467	0	110,467		10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services	0	0	0	0		15.00
16.00	Spiritual Counseling	0	0	0	0		16.00
17.00	Dietary Counseling	0	0	0	0		17.00
18.00	Counseling - Other	0	0	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		20.00
21.00	Other	0	0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0		22.00
23.00	Analgesics	0	0	0	0		23.00
24.00	Sedatives / Hypnotics	0	0	0	0		24.00
25.00	Other - Specify	0	0	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0		26.00
27.00	Patient Transportation	0	0	0	0		27.00
28.00	Imaging Services	0	0	0	0		28.00
29.00	Labs and Diagnostics	0	0	0	0		29.00
30.00	Medical Supplies	0	0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0		31.00
32.00	Radiation Therapy	0	0	0	0		32.00
33.00	Chemotherapy	0	0	0	0		33.00
34.00	Other	0	0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0		35.00
36.00	Volunteer Program Costs	0	0	0	0		36.00
37.00	Fundraising	0	0	0	0		37.00
38.00	Other Program Costs	0	0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	110,467	0	110,467		39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150115
Hospice CCN:

Period:
From 07/01/2010
To 06/30/2011

Worksheet K-4
Part II
Date/Time Prepared:
3/28/2012 1:31 pm

Hospice I

		CAPITAL RELATED COST					
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT ($ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		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	100		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	100	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	9,027	0	39.00
40.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	90.270000	0.000000	40.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 150115 Hospice CCN:	Period: From 07/01/2010 To 06/30/2011	Worksheet K-4 Part II Date/Time Prepared: 3/28/2012 1:31 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	0	110,467	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	110,467	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	0	12.00
13.00	Occupational Therapy	0	0	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	0	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
	OTHER HOSPICE SERVICE COSTS			
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE			
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		0	39.00
40.00	Unit Cost Multiplier		0.000000	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150115
Hospice CCN:

Period:
From 07/01/2010
To 06/30/2011

Worksheet K-5
Part I
Date/Time Prepared:
3/28/2012 1:31 pm

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		0	1.00	2.00	4.00	4A	
1.00	Administrative and General		7,119	8,341	24,390	39,850	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	110,467	0	0	0	110,467	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)	110,467	7,119	8,341	24,390	150,317	34.00
35.00	Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150115
Hospice CCN:

Period:
From 07/01/2010
To 06/30/2011

Worksheet K-5
Part I
Date/Time Prepared:
3/28/2012 1:31 pm

Hospice I

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
1.00	Administrative and General	6,601	17,465	0	3,361	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	18,297	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)	24,898	17,465	0	3,361	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150115
Hospice CCN:

Period:
From 07/01/2010
To 06/30/2011

Worksheet K-5
Part I
Date/Time Prepared:
3/28/2012 1:31 pm

Hospice I

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	1,513	0	0	6	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)	1,513	0	0	6	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150115
Hospice CCN:

Period:
From 07/01/2010
To 06/30/2011

Worksheet K-5
Part I
Date/Time Prepared:
3/28/2012 1:31 pm

Hospice I

	Cost Center Description	Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	68,796					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	128,764	0	128,764	68,796	197,560	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)	197,560	0	197,560		197,560	34.00
35.00	Unit Cost Multiplier (see instructions)				0.534280		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150115
Hospice CCN:

Period:
From 07/01/2010
To 06/30/2011

Worksheet K-5
Part II
Date/Time Prepared:
3/28/2012 1:31 pm

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
1.00	Administrative and General	975	975	97,711	0	39,850	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	110,467	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)	975	975	97,711		150,317	34.00
35.00	Total cost to be allocated	7,119	8,341	24,390		24,898	35.00
36.00	Unit Cost Multiplier (see instructions)	7.301538	8.554872	0.249614		0.165637	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150115
Hospice CCN:

Period:
From 07/01/2010
To 06/30/2011

Worksheet K-5
Part II
Date/Time Prepared:
3/28/2012 1:31 pm

Hospice I

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
		6.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	975	0	975	0	2,466	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)	975	0	975	0	2,466	34.00
35.00	Total cost to be allocated	17,465	0	3,361	0	1,513	35.00
36.00	Unit Cost Multiplier (see instructions)	17.912821	0.000000	3.447179	0.000000	0.613544	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150115
Hospice CCN:

Period:
From 07/01/2010
To 06/30/2011

Worksheet K-5
Part II
Date/Time Prepared:
3/28/2012 1:31 pm

Hospice I

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)		
		13.00	14.00	15.00	16.00		
1.00	Administrative and General	0	0	4	0		1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	0	0	0		4.00
5.00	Nursing Care	0	0	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00	Physical Therapy	0	0	0	0		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0	0		11.00
12.00	Dietary Counseling	0	0	0	0		12.00
13.00	Counseling - Other	0	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00	Other	0	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00	Analgesics	0	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0	0		19.00
20.00	Other - Specify	0	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00	Patient Transportation	0	0	0	0		22.00
23.00	Imaging Services	0	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0	0		24.00
25.00	Medical Supplies	0	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00	Radiation Therapy	0	0	0	0		27.00
28.00	Chemotherapy	0	0	0	0		28.00
29.00	Other	0	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0	0		31.00
32.00	Fundraising	0	0	0	0		32.00
33.00	Other Program Costs	0	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	4	0		34.00
35.00	Total cost to be allocated	0	0	6	0		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	1.500000	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 150115
Hospice CCN:

Period:
From 07/01/2010
To 06/30/2011

Worksheet K-5
Part III
Date/Time Prepared:
3/28/2012 1:31 pm

Hospice I

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.666304	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00				2.00
3.00	SPEECH PATHOLOGY	68.00				3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.215730	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0.000000	0	0	5.00
6.00	LABORATORY	60.00	0.351361	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.420812	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	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00				10.00
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 150115
Hospice CCN:

Period:
From 07/01/2010
To 06/30/2011

Worksheet K-6
Date/Time Prepared:
3/28/2012 1:31 pm

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				197,560	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				0	2.00
3.00	Average cost per diem (line 1 divided by line 2)				0.00	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	0				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	0				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		0			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		0			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			0		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			0		13.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150115	Period: From 07/01/2010 To 06/30/2011	Worksheet L Parts I-III Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,668,568	1.00
2.00	Capital DRG outlier payments	8,659	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	53.36	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)	0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)	1,677,227	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

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

Provider CCN: 150115
Component CCN: 158507

Period: From 07/01/2010 To 06/30/2011

Worksheet M-1
Date/Time Prepared: 3/28/2012 1:31 pm

Title XVIII | Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	3,825	3,825	0	3,825	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	112,607	0	112,607	0	112,607	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	112,607	3,825	116,432	0	116,432	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	18,565	18,565	0	18,565	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	63,311	50,140	113,451	0	113,451	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	63,311	68,705	132,016	0	132,016	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	175,918	72,530	248,448	0	248,448	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	175,918	72,530	248,448	0	248,448	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 150115 Component CCN: 158507	Period: From 07/01/2010 To 06/30/2011	Worksheet M-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	3,825		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	112,607		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	116,432		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	0		14.00
15.00	Medical Supplies	0	18,565		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	-15,820	97,631		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	-15,820	116,196		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-15,820	232,628		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-15,820	232,628		32.00

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

Provider CCN: 150115
Component CCN: 158508

Period: From 07/01/2010 To 06/30/2011

Worksheet M-1
Date/Time Prepared: 3/28/2012 1:31 pm

Title XVIII | Rural Health Clinic (RHC) II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	160,770	0	160,770	0	160,770	1.00
2.00	Physician Assistant	108,133	0	108,133	0	108,133	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	48,872	0	48,872	0	48,872	9.00
10.00	Subtotal (sum of lines 1-9)	317,775	0	317,775	0	317,775	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	19,594	19,594	0	19,594	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	77,105	47,480	124,585	0	124,585	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	77,105	67,074	144,179	0	144,179	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	394,880	67,074	461,954	0	461,954	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	394,880	67,074	461,954	0	461,954	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 150115 Component CCN: 158508	Period: From 07/01/2010 To 06/30/2011	Worksheet M-1 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	160,770		1.00
2.00	Physician Assistant	0	108,133		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	48,872		9.00
10.00	Subtotal (sum of lines 1-9)	0	317,775		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	0		14.00
15.00	Medical Supplies	0	19,594		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	-43,254	81,331		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	-43,254	100,925		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-43,254	418,700		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-43,254	418,700		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 150115
Component CCN: 158507

Period: From 07/01/2010 To 06/30/2011

Worksheet M-2
Date/Time Prepared: 3/28/2012 1:31 pm

Title XVIII | Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.90	3,052	2,100	1,890		3.00
4.00	Subtotal (sum of lines 1-3)	0.90	3,052		1,890	3,052	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	0.90	3,052			3,052	8.00
9.00	Physician Services Under Agreements		265			265	9.00
						1.00	

	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)	232,628	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	232,628	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)	0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	189,493	15.00
16.00	Total overhead (sum of lines 14 and 15)	189,493	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtract line 17 from line 16	189,493	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	189,493	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	422,121	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 150115
Component CCN: 158508

Period: From 07/01/2010 To 06/30/2011

Worksheet M-2
Date/Time Prepared: 3/28/2012 1:31 pm

Title XVIII | Rural Health Clinic (RHC) II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.91	4,245	4,200	3,822		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.93	2,800	2,100	1,953		3.00
4.00	Subtotal (sum of lines 1-3)	1.84	7,045		5,775	7,045	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.84	7,045			7,045	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					418,700	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					418,700	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					474,681	15.00
16.00	Total overhead (sum of lines 14 and 15)					474,681	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					474,681	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					474,681	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					893,381	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 150115 Component CCN: 158507	Period: From 07/01/2010 To 06/30/2011	Worksheet M-3 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		422,121	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		422,121	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		3,052	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		265	5.00
6.00	Total adjusted visits (line 4 plus line 5)		3,317	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		127.26	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	77.76	78.07	8.00
9.00	Rate for Program covered visits (see instructions)	77.76	78.07	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	393	480	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	30,560	37,474	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	30,560	37,474	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		18,801	16.04
16.05	Total program cost (see instructions)	24,448	18,801	16.05
17.00	Primary payer amounts		127	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		13,973	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		17,420	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		43,122	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		43,122	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		43,122	26.00
27.00	Interim payments		42,460	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		662	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 150115 Component CCN: 158508	Period: From 07/01/2010 To 06/30/2011	Worksheet M-3 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		893,381	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		893,381	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		7,045	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		7,045	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		126.81	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	77.76	78.07	8.00
9.00	Rate for Program covered visits (see instructions)	77.76	78.07	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,014	1,068	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	78,849	83,379	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	78,849	83,379	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		40,502	16.04
16.05	Total program cost (see instructions)	63,079	40,502	16.05
17.00	Primary payer amounts		86	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		32,752	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		37,468	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		103,495	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		103,495	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		103,495	26.00
27.00	Interim payments		102,261	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		1,234	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 150115 Component CCN: 158507	Period: From 07/01/2010 To 06/30/2011	Worksheet M-5 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		42,460	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		42,460	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		662	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		43,122	7.00

			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 150115 Component CCN: 158508	Period: From 07/01/2010 To 06/30/2011	Worksheet M-5 Date/Time Prepared: 3/28/2012 1:31 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		102,261	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		102,261	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		1,234	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		103,495	7.00

			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00