This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 151310

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

Worksheet S Parts I-III
Date/Time Prepared: 5/14/2012 10:41 am

PART I - COST REPORT STATUS

Date: 5/14/2012 Time: 10:41 am

Provider use only
1. [ ] Electronically filed cost report
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: 04
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 WABASH COUNTY HOSPITAL for the cost reporting period beginning 01/01/2011 and ending 12/31/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information
ECR: Date: 5/14/2012 Time: 10:41 am
4NolaOcxXftX9eR9iEkuOSISzaAsjO
seHmoOfLlQoEKIuyZMMCppdHX894Cq
YTkEOqodgHOiEOOB
PI: Date: 5/14/2012 Time: 10:41 am
jy8XzSaKDVpA3Ry.frqUYDxzOg4YW1
fKSBBOhaRltSGB6lSjEatOY3p8veJj
3UE54iVRxAOnWCIy

(Signed) [signature]
Officer or Administrator of Provider(s)

President / CEO
Title

5/25/12
Date

		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	308,016	163,129	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	3,194	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	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	RURAL HEALTH CLINIC I	0		0		0	10.00
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	311,210	163,129	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.

Health Financial Systems | WABASH COUNTY HOSPITAL | In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S Parts I-III Date/Time Prepared: 5/14/2012 10:41 am

PART I - COST REPORT STATUS

Date: 5/14/2012 Time: 10:41 am

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(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	308,016	163,129	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	3,194	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	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	RURAL HEALTH CLINIC I	0		0		0	10.00
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	311,210	163,129	0	0	200.00

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FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 151310

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

Worksheet S
Parts I-III
Date/Time Prepared:
5/14/2012 10:41 am

PART I - COST REPORT STATUS

Provider use only

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Date: 5/14/2012 Time: 10:41 am

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YTkEOqodgHOiEOOB
PI: Date: 5/14/2012 Time: 10:41 am
jy8XZSaKDVpA3Ry.frqUYDxzOg4YW1
fKSBBOhaRltSGB6lSjEatOY3p8veJj
3UE54iVRxAOnWCIy

(Signed)
Officer or Administrator of Provider(s)

Title

Date

		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						
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4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	3,194	0		0	5.00
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8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
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	311,210	163,129	0	0	200.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part I | Date/Time Prepared: 5/14/2012 10:12 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 710 NORTH EAST STREET	PO Box: 548			1.00
2.00	City: WABASH	State: IN	Zip Code: 46992-0548	County: WABASH	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	WABASH COUNTY HOSPITAL	151310	15999	1	12/17/2001	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	WABASH COUNTY HOSPITAL SWING BEDS	15Z310	15999		12/17/2001	N	O	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF	WABASH COUNTY HOSPITAL SNF	155365	15999		01/01/1993	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	WABASH COUNTY HOME HEALTH AGENCY	157061	15999		01/01/1979	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	WABASH COUNTY HOSPITAL HOSPICE	151545	15999		01/01/1996				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2011	12/31/2011	20.00
21.00	Type of Control (see instructions)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.	2	N	23.00

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

		Urban/Rural S 1.00	Date of Geogr 2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.	2		26.00
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification (in column 2).	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. 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	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00

Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
1.00	2.00	3.00	4.00	5.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4.			0.00	0.00	0.000000	65.00

	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
	1.00	2.00	3.00

Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010

66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

Inpatient Psychiatric Facility PPS

		1.00	2.00	3.00	
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00

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

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	N	86.00

		V 1.00	XIX 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)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	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		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0		118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.	0	0	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

		1.00	2.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

1.00	2.00	3.00

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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)

		Part A 1.00	Part B 2.00	
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 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 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: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part II | Date/Time Prepared: 5/14/2012 10:12 am

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

		Y/N	Date		
		1.00	2.00		
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

Financial Data and Reports

		Y/N	Type	Date	
		1.00	2.00	3.00	
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	05/15/2012	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

Approved Educational Activities

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

		Y/N	
		1.00	

Bad Debts

12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00

Bed Complement

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

		Description	Part A Y/N	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	04/09/2012		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N			20.00

		Description	Part A 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	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N/A		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N/A		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N/A		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N/A		40.00

		Part B Y/N 3.00	Part B Date 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	04/09/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I Date/Time Prepared: 5/14/2012 10:12 am

	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	20	7,300	32,256.00	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)		20	7,300	32,256.00	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	17,664.00	8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY	43.00				13.00
14.00	Total (see instructions)		25	9,125	49,920.00	14.00
15.00	CAH visits					15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY	44.00	25	9,125		19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY	101.00				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE	116.00	0	0		24.00
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00	Total (sum of lines 14-26)		50			27.00
28.00	Observation Bed Days					28.00
29.00	Ambulance Trips					29.00
30.00	Employee discount days (see instruction)					30.00
31.00	Employee discount days - IRF					31.00
32.00	Labor & delivery days (see instructions)					32.00
33.00	LTCH non-covered days					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/14/2012 10:12 am

	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	590	34	1,344	1.00
2.00	HMO		318	0		2.00
3.00	HMO IPF		0	0		3.00
4.00	HMO IRF		0	0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	53	0	53	5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		48	48	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	643	82	1,445	7.00
8.00	INTENSIVE CARE UNIT	0	434	17	736	8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY	0		0	0	13.00
14.00	Total (see instructions)	0	1,077	99	2,181	14.00
15.00	CAH visits	0	0	0	0	15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY	0	1,262	0	5,704	19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY	0	3,014	0	14,306	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE		0	0	0	24.00
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00	Total (sum of lines 14-26)					27.00
28.00	Observation Bed Days	0		0	293	28.00
29.00	Ambulance Trips		0			29.00
30.00	Employee discount days (see instruction)				0	30.00
31.00	Employee discount days - IRF				0	31.00
32.00	Labor & delivery days (see instructions)			0	0	32.00
33.00	LTCH non-covered days		0			33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I Date/Time Prepared: 5/14/2012 10:12 am

	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	317	1.00
2.00	HMO					87	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	349.94	0.00	0	317	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00	26.30	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	23.93	0.00			22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00	12.40	0.00			24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00	412.57	0.00			27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Discharges Title XIX	Discharges 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)	23	660	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)	23	660	14.00
15.00	CAH visits			15.00
16.00	SUBPROVIDER - IPF			16.00
17.00	SUBPROVIDER - IRF			17.00
18.00	SUBPROVIDER			18.00
19.00	SKILLED NURSING FACILITY			19.00
20.00	NURSING FACILITY			20.00
21.00	OTHER LONG TERM CARE			21.00
22.00	HOME HEALTH AGENCY			22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)			23.00
24.00	HOSPICE			24.00
25.00	CMHC - CMHC			25.00
26.00	RURAL HEALTH CLINIC			26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER			26.25
27.00	Total (sum of lines 14-26)			27.00
28.00	Observation Bed Days			28.00
29.00	Ambulance Trips			29.00
30.00	Employee discount days (see instruction)			30.00
31.00	Employee discount days - IRF			31.00
32.00	Labor & delivery days (see instructions)			32.00
33.00	LTCH non-covered days			33.00

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3.00
4.00	Prior Year Pension Service Cost	636,531	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)	3,097,449	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)	27,626	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)	38,772	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	141,775	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	976,796	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	74,982	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	36,390	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,030,321	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 151310
Component CCN: 157061

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

Worksheet S-4
Date/Time Prepared: 5/14/2012 10:12 am

		Home Health Agency I	PPS
		1.00	
0.00	County	WABASH	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	136.00	65.00	147.00	378.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent) Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		0.00	0.00	0.00	5.00
6.00	Direct Nursing Service		0.00	0.00	0.00	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		15999			20.00

		Full Episodes 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	1,005	21	36	20	1,082	21.00
22.00	Skilled Nursing Visit Charges	542,500	12,460	25,340	15,260	595,560	22.00
23.00	Physical Therapy Visits	916	0	7	7	930	23.00
24.00	Physical Therapy Visit Charges	511,415	0	3,770	4,060	519,245	24.00
25.00	Occupational Therapy Visits	145	4	1	4	154	25.00
26.00	Occupational Therapy Visit Charges	73,950	1,885	580	2,030	78,445	26.00
27.00	Speech Pathology Visits	7	0	0	0	7	27.00
28.00	Speech Pathology Visit Charges	3,480	0	0	0	3,480	28.00
29.00	Medical Social Service Visits	3	0	0	0	3	29.00
30.00	Medical Social Service Visit Charges	510	0	0	0	510	30.00
31.00	Home Health Aide Visits	822	8	6	2	838	31.00
32.00	Home Health Aide Visit Charges	66,582	648	486	162	67,878	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,898	33	50	33	3,014	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)	1,198,437	14,993	30,176	21,512	1,265,118	35.00
36.00	Total Number of Episodes (standard/non outlier)	155		20	4	179	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	106	0	2	0	108	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-7 | Date/Time Prepared: 5/14/2012 10:12 am

		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.	N		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.	Y	12/17/2001	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	0	0	0	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	0	0	0	7.00
8.00	RHL	0	0	0	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	0	0	0	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	0	0	0	14.00
15.00	RVC	0	0	0	15.00
16.00	RVB	0	0	0	16.00
17.00	RVA	0	0	0	17.00
18.00	RHC	44	0	44	18.00
19.00	RHB	31	0	31	19.00
20.00	RHA	127	0	127	20.00
21.00	RMC	82	0	82	21.00
22.00	RMB	162	0	162	22.00
23.00	RMA	392	0	392	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	0	0	0	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	14	0	14	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	41	0	41	32.00
33.00	HC2	0	0	0	33.00
34.00	HC1	17	0	17	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	50	0	50	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	1	0	1	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	45	0	45	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	0	0	0	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	0	0	0	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	12	0	12	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	38	0	38	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	51	0	51	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	97	0	97	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	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	0	0	0	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	19	0	19	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: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-7 | Date/Time Prepared: 5/14/2012 10:12 am

		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	3	0	3	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	28	0	28	78.00
199.00		AAA	8	0	8	199.00
200.00	TOTAL		1,262	0	1,262	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	
201.00	SNF SERVICES 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).	15999	15999	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)	1,620,843			207.00

HOSPITAL IDENTIFICATION DATA

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet S-9 Parts I & II

Component CCN: 151545 Date/Time Prepared: 5/14/2012 10:12 am

Hospice I

		Unduplicated Days					
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ENROLLMENT DAYS						
1.00	Continuous Home Care	0	0	0	0	0	1.00
2.00	Routine Home Care	7,872	315	0	0	367	2.00
3.00	Inpatient Respite Care	69	8	0	0	5	3.00
4.00	General Inpatient Care	0	0	0	0	0	4.00
5.00	Total Hospice Days	7,941	323	0	0	372	5.00
	Part II - CENSUS DATA						
6.00	Number of Patients Receiving Hospice Care	0	0	0	0	0	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00			7.00
8.00	Average Length of Stay (line 5/line 6)	0.00	0.00	0.00	0.00	0.00	8.00
9.00	Unduplicated Census Count	112	0	0	0	0	9.00

HOSPITAL IDENTIFICATION DATA

Provider CCN: 151310
Component CCN: 151545

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

Worksheet S-9
Parts I & II
Date/Time Prepared:
5/14/2012 10:12 am

Hospice I

		Unduplicated Days Total (sum of cols. 1, 2 & 5) 6.00	
	PART I - ENROLLMENT DAYS		
1.00	Continuous Home Care	0	1.00
2.00	Routine Home Care	8,554	2.00
3.00	Inpatient Respite Care	82	3.00
4.00	General Inpatient Care	0	4.00
5.00	Total Hospice Days	8,636	5.00
	Part II - CENSUS DATA		
6.00	Number of Patients Receiving Hospice Care	0	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare		7.00
8.00	Average Length of Stay (line 5/line 6)	0.00	8.00
9.00	Unduplicated Census Count	112	9.00

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)	0.412827	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	501,796	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	597,670	5.00
6.00	Medicaid charges	4,345,105	6.00
7.00	Medicaid cost (line 1 times line 6)	1,793,777	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)	694,311	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)	92,787	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	435,192	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	179,659	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)	86,872	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	4,274	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)	781,183	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	1,240,010	0	1,240,010	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	511,910	0	511,910	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)	511,910	0	511,910	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)	2,086,715	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	532,416	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	1,554,299	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	641,657	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,153,567	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,934,750	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet A Date/Time Prepared: 5/14/2012 10:12 am

	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	NEW CAP REL COSTS-BLDG & FIXT		463,907	463,907	0	463,907	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		1,130,742	1,130,742	6,293	1,137,035	2.00
4.00	EMPLOYEE BENEFITS	139,004	406,730	545,734	2,206	547,940	4.00
5.00	ADMINISTRATIVE & GENERAL	1,656,029	2,507,011	4,163,040	6,269	4,169,309	5.00
6.00	MAINTENANCE & REPAIRS	335,302	324,636	659,938	0	659,938	6.00
7.00	OPERATION OF PLANT	0	569,219	569,219	0	569,219	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	HOUSEKEEPING	304,821	428,473	733,294	0	733,294	9.00
10.00	DIETARY	520,484	697,609	1,218,093	-884,817	333,276	10.00
11.00	CAFETERIA	0	0	0	884,817	884,817	11.00
13.00	NURSING ADMINISTRATION	154,733	45,547	200,280	0	200,280	13.00
14.00	CENTRAL SERVICES & SUPPLY	28,943	1,505,770	1,534,713	-20,278	1,514,435	14.00
15.00	PHARMACY	639,049	2,531,003	3,170,052	-12,562	3,157,490	15.00
16.00	MEDICAL RECORDS & LIBRARY	347,687	465,031	812,718	0	812,718	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	920,344	371,109	1,291,453	0	1,291,453	30.00
31.00	INTENSIVE CARE UNIT	561,209	226,487	787,696	0	787,696	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	636,085	328,614	964,699	0	964,699	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	629,889	604,282	1,234,171	0	1,234,171	50.00
51.00	RECOVERY ROOM	63,517	20,477	83,994	0	83,994	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	584,238	704,879	1,289,117	0	1,289,117	53.00
54.00	RADIOLOGY-DIAGNOSTIC	743,556	1,244,086	1,987,642	0	1,987,642	54.00
56.00	RADIOISOTOPE	75,144	140,994	216,138	0	216,138	56.00
60.00	LABORATORY	759,485	1,132,257	1,891,742	0	1,891,742	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	116,578	116,578	0	116,578	63.00
66.00	PHYSICAL THERAPY	769,177	418,914	1,188,091	0	1,188,091	66.00
69.00	ELECTROCARDIOLOGY	500,165	258,625	758,790	0	758,790	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	20,278	20,278	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	244,774	244,774	0	244,774	90.00
90.01	SENIOR CARE	138,853	150,073	288,926	0	288,926	90.01
91.00	EMERGENCY	810,153	1,820,409	2,630,562	0	2,630,562	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	830,756	531,763	1,362,519	0	1,362,519	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	409,464	396,858	806,322	0	806,322	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	12,558,087	19,786,857	32,344,944	2,206	32,347,150	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	2,793,127	2,025,375	4,818,502	0	4,818,502	192.00
194.00	FITNESS CENTER	13,103	6,701	19,804	-2,206	17,598	194.00
194.01	MARKETING	65,216	129,460	194,676	0	194,676	194.01
194.02	NEW DIRECTION	0	0	0	0	0	194.02
194.03	RESPITE	0	0	0	0	0	194.03
194.04	WELL CHILD CLINIC	95,570	46,545	142,115	0	142,115	194.04
200.00	TOTAL (SUM OF LINES 118-199)	15,525,103	21,994,938	37,520,041	0	37,520,041	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A | Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	-44,835	419,072	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-6,293	1,130,742	2.00
4.00	EMPLOYEE BENEFITS	-1,813	546,127	4.00
5.00	ADMINISTRATIVE & GENERAL	-330,740	3,838,569	5.00
6.00	MAINTENANCE & REPAIRS	-550	659,388	6.00
7.00	OPERATION OF PLANT	-8,129	561,090	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	HOUSEKEEPING	0	733,294	9.00
10.00	DIETARY	0	333,276	10.00
11.00	CAFETERIA	-234,639	650,178	11.00
13.00	NURSING ADMINISTRATION	0	200,280	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	1,514,435	14.00
15.00	PHARMACY	-126,147	3,031,343	15.00
16.00	MEDICAL RECORDS & LIBRARY	-15,236	797,482	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	0	1,291,453	30.00
31.00	INTENSIVE CARE UNIT	0	787,696	31.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	964,699	44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0	1,234,171	50.00
51.00	RECOVERY ROOM	0	83,994	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	ANESTHESIOLOGY	-1,254,162	34,955	53.00
54.00	RADIOLOGY-DIAGNOSTIC	-99	1,987,543	54.00
56.00	RADIOISOTOPE	0	216,138	56.00
60.00	LABORATORY	-17,089	1,874,653	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	116,578	63.00
66.00	PHYSICAL THERAPY	0	1,188,091	66.00
69.00	ELECTROCARDIOLOGY	-60,001	698,789	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	20,278	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	0	244,774	90.00
90.01	SENIOR CARE	0	288,926	90.01
91.00	EMERGENCY	-866,738	1,763,824	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	OTHER REIMBURSABLE COST CENTERS			
101.00	HOME HEALTH AGENCY	0	1,362,519	101.00
	SPECIAL PURPOSE COST CENTERS			
116.00	HOSPICE	0	806,322	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-2,966,471	29,380,679	118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	4,818,502	192.00
194.00	FITNESS CENTER	0	17,598	194.00
194.01	MARKETING	0	194,676	194.01
194.02	NEW DIRECTION	0	0	194.02
194.03	RESPITE	0	0	194.03
194.04	WELL CHILD CLINIC	0	142,115	194.04
200.00	TOTAL (SUM OF LINES 118-199)	-2,966,471	34,553,570	200.00

	Cost Center	Increases Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	378,077	506,740	1.00
	TOTALS		378,077	506,740	
	B - TUMOR REGISTRY				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,562	1.00
	TOTALS		0	12,562	
	E - INTEREST				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	6,293	1.00
	TOTALS		0	6,293	
	F - FITNESS CENTER				
1.00	EMPLOYEE BENEFITS	4.00	1,460	746	1.00
	TOTALS		1,460	746	
	G - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	20,278	1.00
	TOTALS		0	20,278	
500.00	Grand Total: Increases		379,537	546,619	500.00

RECLASSIFICATIONS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-6 | Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center	Decreases Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA					
1.00	DIETARY	10.00	378,077	506,740	0	1.00
	TOTALS		378,077	506,740		
	B - TUMOR REGISTRY					
1.00	PHARMACY	15.00	0	12,562	0	1.00
	TOTALS		0	12,562		
	E - INTEREST					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,293	10	1.00
	TOTALS		0	6,293		
	F - FITNESS CENTER					
1.00	FITNESS CENTER	194.00	1,460	746	0	1.00
	TOTALS		1,460	746		
	G - IMPLANTABLE DEVICES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	20,278	0	1.00
	TOTALS		0	20,278		
500.00	Grand Total: Decreases		379,537	546,619		500 00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 5/14/2012 10:12 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: 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	475,705	0	0	0	0	1.00
2.00	Land Improvements	359,678	0	0	0	44,979	2.00
3.00	Buildings and Fixtures	14,138,490	98,292	0	98,292	0	3.00
4.00	Building Improvements	3,590,144	45,774	0	45,774	0	4.00
5.00	Fixed Equipment	1,044,533	0	0	0	198,539	5.00
6.00	Movable Equipment	13,009,634	0	0	0	1,001,373	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,618,184	144,066	0	144,066	1,244,891	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	32,618,184	144,066	0	144,066	1,244,891	10.00

SUMMARY OF CAPITAL

	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	463,907	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,130,742	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,594,649	0	0	0	0	3.00

COMPUTATION OF RATIOS

	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 5/14/2012 10:12 am

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	475,705	0	1.00
2.00	Land Improvements	314,699	0	2.00
3.00	Buildings and Fixtures	14,236,782	0	3.00
4.00	Building Improvements	3,635,918	0	4.00
5.00	Fixed Equipment	845,994	0	5.00
6.00	Movable Equipment	12,008,261	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,517,359	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	31,517,359	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	NEW CAP REL COSTS-BLDG & FIXT	0	463,907	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,130,742	2.00
3.00	Total (sum of lines 1-2)	0	1,594,649	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	419,072	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,130,742	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,549,814	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III Date/Time Prepared: 5/14/2012 10:12 am

	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	419,072	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,130,742	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,549,814	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8 | Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-6,293	NEW 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)	B	-2,568	ADMINISTRATIVE & GENERAL	5.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00	Television and radio service (chapter 21)	B	-8,129	OPERATION OF PLANT	7.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-926,653			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-234,639	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	-126,147	PHARMACY	15.00	17.00
18.00	Sale of medical records and abstracts	B	-15,236	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	-550	MAINTENANCE & REPAIRS	6.00	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	*** Cost Center Deleted ***	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW 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	A	0		0.00	32.00
33.00	DEVELOPMENT	A	-156,041	ADMINISTRATIVE & GENERAL	5.00	33.00
35.00	MISC REVENUE	B	-3,358	ADMINISTRATIVE & GENERAL	5.00	35.00
37.00	LAB FEES	B	-17,089	LABORATORY	60.00	37.00
38.00	CARDIAC FEES	B	-86	ELECTROCARDIOLOGY	69.00	38.00
40.00	ANESTHESIA	B	-1,254,162	ANESTHESIOLOGY	53.00	40.00
42.00	PHYSICIAN RECRUITING	A	-159,479	ADMINISTRATIVE & GENERAL	5.00	42.00
43.00	LOBBYING	A	-9,294	ADMINISTRATIVE & GENERAL	5.00	43.00
44.00	PROPERTY TAXES	A	-44,835	NEW CAP REL COSTS-BLDG & FIXT	1.00	44.00
45.01	FITNESS CENTER	B	-1,813	EMPLOYEE BENEFITS	4.00	45.01
45.02	MRI	B	-99	RADIOLOGY-DIAGNOSTIC	54.00	45.02
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,966,471			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet A-8 Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Wkst. A-7 Ref. 5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	10	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	DEVELOPMENT	0	33.00
35.00	MISC REVENUE	0	35.00
37.00	LAB FEES	0	37.00
38.00	CARDIAC FEES	0	38.00
40.00	ANESTHESIA	0	40.00
42.00	PHYSICIAN RECRUITING	0	42.00
43.00	LOBBYING	0	43.00
44.00	PROPERTY TAXES	9	44.00
45.01	FITNESS CENTER	0	45.01
45.02	MRI	0	45.02
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: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/14/2012 10:12 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	69.00	ELECTROCARDIOLOGY	59,915	59,915	1.00
2.00	91.00	EMERGENCY	1,509,295	866,738	2.00
3.00	0.00		0	0	3.00
4.00	0.00		0	0	4.00
5.00	0.00		0	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			1,569,210	926,653	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/14/2012 10:12 am

	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	642,557	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	642,557		0	0	0	200.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/14/2012 10:12 am

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	59,915	1.00
2.00	0	866,738	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	926,653	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	419,072	419,072				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,130,742		1,130,742			2.00
4.00	EMPLOYEE BENEFITS	546,127	9,569	9,256	564,952		4.00
5.00	ADMINISTRATIVE & GENERAL	3,838,569	26,158	335,331	60,813	4,260,871	5.00
6.00	MAINTENANCE & REPAIRS	659,388	0	246,928	12,313	918,629	6.00
7.00	OPERATION OF PLANT	561,090	75,707	0	0	636,797	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	HOUSEKEEPING	733,294	6,370	147	11,194	751,005	9.00
10.00	DIETARY	333,276	16,453	1,989	5,229	356,947	10.00
11.00	CAFETERIA	650,178	5,103	0	13,884	669,165	11.00
13.00	NURSING ADMINISTRATION	200,280	1,593	0	5,682	207,555	13.00
14.00	CENTRAL SERVICES & SUPPLY	1,514,435	17,369	822	1,063	1,533,689	14.00
15.00	PHARMACY	3,031,343	10,441	1,112	23,467	3,066,363	15.00
16.00	MEDICAL RECORDS & LIBRARY	797,482	13,560	624	12,768	824,434	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,291,453	30,043	2,526	33,797	1,357,819	30.00
31.00	INTENSIVE CARE UNIT	787,696	6,005	5,847	20,609	820,157	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	964,699	22,243	7,562	23,358	1,017,862	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,234,171	27,279	102,087	23,131	1,386,668	50.00
51.00	RECOVERY ROOM	83,994	3,145	0	2,332	89,471	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	34,955	567	0	21,454	56,976	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,987,543	21,954	288,962	27,305	2,325,764	54.00
56.00	RADIOISOTOPE	216,138	0	769	2,759	219,666	56.00
60.00	LABORATORY	1,874,653	11,301	32,816	27,890	1,946,660	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	116,578	0	0	0	116,578	63.00
66.00	PHYSICAL THERAPY	1,188,091	2,787	9,076	28,246	1,228,200	66.00
69.00	ELECTROCARDIOLOGY	698,789	3,407	15,729	18,367	736,292	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	20,278	0	0	0	20,278	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	244,774	3,228	12,851	0	260,853	90.00
90.01	SENIOR CARE	288,926	6,818	0	5,099	300,843	90.01
91.00	EMERGENCY	1,763,824	10,906	7,825	29,750	1,812,305	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	1,362,519	6,337	0	30,507	1,399,363	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	806,322	0	0	15,036	821,358	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	29,380,679	338,343	1,082,259	456,053	29,142,568	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,654	0	0	2,654	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	4,818,502	56,705	48,369	102,566	5,026,142	192.00
194.00	FITNESS CENTER	17,598	11,387	0	428	29,413	194.00
194.01	MARKETING	194,676	803	0	2,395	197,874	194.01
194.02	NEW DIRECTION	0	0	0	0	0	194.02
194.03	RESPITE	0	0	0	0	0	194.03
194.04	WELL CHILD CLINIC	142,115	9,180	114	3,510	154,919	194.04
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)	34,553,570	419,072	1,130,742	564,952	34,553,570	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	4,260,871					5.00
6.00	MAINTENANCE & REPAIRS	129,212	1,047,841				6.00
7.00	OPERATION OF PLANT	89,570	206,936	933,303			7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0		8.00
9.00	HOUSEKEEPING	105,634	17,412	19,326	0	893,377	9.00
10.00	DIETARY	50,207	44,973	49,915	0	0	10.00
11.00	CAFETERIA	94,123	13,948	15,481	0	0	11.00
13.00	NURSING ADMINISTRATION	29,194	4,353	4,831	0	906	13.00
14.00	CENTRAL SERVICES & SUPPLY	215,724	47,476	52,693	0	49,379	14.00
15.00	PHARMACY	431,305	28,540	31,676	0	29,684	15.00
16.00	MEDICAL RECORDS & LIBRARY	115,962	37,065	41,138	0	9,706	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	190,987	82,120	91,143	0	119,574	30.00
31.00	INTENSIVE CARE UNIT	115,361	16,415	18,219	0	23,902	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	143,169	60,799	67,479	0	88,529	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	195,045	74,565	82,759	0	77,553	50.00
51.00	RECOVERY ROOM	12,585	8,597	9,542	0	8,942	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	8,014	1,551	1,721	0	323	53.00
54.00	RADIOLOGY-DIAGNOSTIC	327,135	60,010	66,603	0	87,380	54.00
56.00	RADIOISOTOPE	30,898	0	0	0	0	56.00
60.00	LABORATORY	273,811	30,889	34,283	0	56,017	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	16,398	0	0	0	0	63.00
66.00	PHYSICAL THERAPY	172,755	7,618	8,455	0	67,687	66.00
69.00	ELECTROCARDIOLOGY	103,565	9,314	10,337	0	67,251	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	2,852	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	36,691	8,824	9,794	0	12,849	90.00
90.01	SENIOR CARE	42,316	18,637	20,685	0	19,384	90.01
91.00	EMERGENCY	254,913	29,810	33,085	0	43,406	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	196,830	17,322	19,225	0	18,016	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	115,530	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,499,786	827,174	688,390	0	780,488	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	373	7,255	8,052	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	706,953	154,998	172,029	0	92,228	192.00
194.00	FITNESS CENTER	4,137	31,125	34,545	0	0	194.00
194.01	MARKETING	27,832	2,195	2,436	0	457	194.01
194.02	NEW DIRECTION	0	0	0	0	0	194.02
194.03	RESPITE	0	0	0	0	0	194.03
194.04	WELL CHILD CLINIC	21,790	25,094	27,851	0	20,204	194.04
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)	4,260,871	1,047,841	933,303	0	893,377	202.00

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	502,042					10.00
11.00	CAFETERIA	0	792,717				11.00
13.00	NURSING ADMINISTRATION	0	6,172	253,011			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	3,426	0	1,902,387		14.00
15.00	PHARMACY	0	35,634	0	0	3,623,202	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	36,940	0	0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	93,827	95,494	69,673	0	0	30.00
31.00	INTENSIVE CARE UNIT	51,827	58,216	42,474	0	0	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	260,610	75,729	0	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	60,163	57,086	41,650	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	4,441	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	8,762	60,129	43,870	0	0	54.00
56.00	RADIOISOTOPE	0	5,346	0	0	0	56.00
60.00	LABORATORY	47	67,257	0	0	0	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	PHYSICAL THERAPY	1,076	35,085	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	37,686	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,902,387	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,623,202	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	1,549	0	0	0	0	90.00
90.01	SENIOR CARE	7,520	7,584	0	0	0	90.01
91.00	EMERGENCY	16,448	75,854	55,344	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	213	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	502,042	662,079	253,011	1,902,387	3,623,202	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	126,584	0	0	0	192.00
194.00	FITNESS CENTER	0	1,596	0	0	0	194.00
194.01	MARKETING	0	2,458	0	0	0	194.01
194.02	NEW DIRECTION	0	0	0	0	0	194.02
194.03	RESPITE	0	0	0	0	0	194.03
194.04	WELL CHILD CLINIC	0	0	0	0	0	194.04
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)	502,042	792,717	253,011	1,902,387	3,623,202	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
6.00	MAINTENANCE & REPAIRS					6.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
14.00	CENTRAL SERVICES & SUPPLY					14.00
15.00	PHARMACY					15.00
16.00	MEDICAL RECORDS & LIBRARY	1,065,245				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	44,009	2,144,646	0	2,144,646	30.00
31.00	INTENSIVE CARE UNIT	30,880	1,177,451	0	1,177,451	31.00
43.00	NURSERY	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	24,369	1,738,546	0	1,738,546	44.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	53,171	2,028,660	0	2,028,660	50.00
51.00	RECOVERY ROOM	4,928	134,065	0	134,065	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	10,472	83,498	0	83,498	53.00
54.00	RADIOLOGY-DIAGNOSTIC	189,927	3,169,580	0	3,169,580	54.00
56.00	RADIOISOTOPE	12,398	268,308	0	268,308	56.00
60.00	LABORATORY	153,371	2,562,335	0	2,562,335	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	3,033	136,009	0	136,009	63.00
66.00	PHYSICAL THERAPY	35,182	1,556,058	0	1,556,058	66.00
69.00	ELECTROCARDIOLOGY	37,285	1,001,730	0	1,001,730	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	59,954	1,962,341	0	1,962,341	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	621	23,751	0	23,751	72.00
73.00	DRUGS CHARGED TO PATIENTS	264,287	3,887,489	0	3,887,489	73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	15,243	345,803	0	345,803	90.00
90.01	SENIOR CARE	8,052	425,021	0	425,021	90.01
91.00	EMERGENCY	74,090	2,395,255	0	2,395,255	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
	OTHER REIMBURSABLE COST CENTERS					
101.00	HOME HEALTH AGENCY	22,435	1,673,404	0	1,673,404	101.00
	SPECIAL PURPOSE COST CENTERS					
116.00	HOSPICE	19,030	955,918	0	955,918	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,062,737	27,669,868	0	27,669,868	118.00
	NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,334	0	18,334	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	2,155	6,281,089	0	6,281,089	192.00
194.00	FITNESS CENTER	0	100,816	0	100,816	194.00
194.01	MARKETING	0	233,252	0	233,252	194.01
194.02	NEW DIRECTION	0	0	0	0	194.02
194.03	RESPITE	0	0	0	0	194.03
194.04	WELL CHILD CLINIC	353	250,211	0	250,211	194.04
200.00	Cross Foot Adjustments		0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,065,245	34,553,570	0	34,553,570	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II | Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	0	9,569	9,256	18,825	18,825	4.00
5.00	ADMINISTRATIVE & GENERAL	0	26,158	335,331	361,489	2,027	5.00
6.00	MAINTENANCE & REPAIRS	0	0	246,928	246,928	410	6.00
7.00	OPERATION OF PLANT	0	75,707	0	75,707	0	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	HOUSEKEEPING	0	6,370	147	6,517	373	9.00
10.00	DIETARY	0	16,453	1,989	18,442	174	10.00
11.00	CAFETERIA	0	5,103	0	5,103	463	11.00
13.00	NURSING ADMINISTRATION	0	1,593	0	1,593	189	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	17,369	822	18,191	35	14.00
15.00	PHARMACY	0	10,441	1,112	11,553	782	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	13,560	624	14,184	426	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	30,043	2,526	32,569	1,127	30.00
31.00	INTENSIVE CARE UNIT	0	6,005	5,847	11,852	687	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	22,243	7,562	29,805	779	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	27,279	102,087	129,366	771	50.00
51.00	RECOVERY ROOM	0	3,145	0	3,145	78	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	567	0	567	715	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	21,954	288,962	310,916	910	54.00
56.00	RADIOISOTOPE	0	0	769	769	92	56.00
60.00	LABORATORY	0	11,301	32,816	44,117	930	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	PHYSICAL THERAPY	0	2,787	9,076	11,863	941	66.00
69.00	ELECTROCARDIOLOGY	0	3,407	15,729	19,136	612	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	3,228	12,851	16,079	0	90.00
90.01	SENIOR CARE	0	6,818	0	6,818	170	90.01
91.00	EMERGENCY	0	10,906	7,825	18,731	992	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	6,337	0	6,337	1,017	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	0	0	0	0	501	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	338,343	1,082,259	1,420,602	15,201	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,654	0	2,654	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	56,705	48,369	105,074	3,413	192.00
194.00	FITNESS CENTER	0	11,387	0	11,387	14	194.00
194.01	MARKETING	0	803	0	803	80	194.01
194.02	NEW DIRECTION	0	0	0	0	0	194.02
194.03	RESPITE	0	0	0	0	0	194.03
194.04	WELL CHILD CLINIC	0	9,180	114	9,294	117	194.04
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	419,072	1,130,742	1,549,814	18,825	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II | Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	363,516					5.00
6.00	MAINTENANCE & REPAIRS	11,024	258,362				6.00
7.00	OPERATION OF PLANT	7,642	51,027	134,376			7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0		8.00
9.00	HOUSEKEEPING	9,012	4,293	2,783	0	22,978	9.00
10.00	DIETARY	4,283	11,089	7,187	0	0	10.00
11.00	CAFETERIA	8,030	3,439	2,229	0	0	11.00
13.00	NURSING ADMINISTRATION	2,491	1,073	696	0	23	13.00
14.00	CENTRAL SERVICES & SUPPLY	18,404	11,706	7,587	0	1,270	14.00
15.00	PHARMACY	36,796	7,037	4,561	0	763	15.00
16.00	MEDICAL RECORDS & LIBRARY	9,893	9,139	5,923	0	250	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	16,294	20,248	13,123	0	3,076	30.00
31.00	INTENSIVE CARE UNIT	9,842	4,047	2,623	0	615	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	12,214	14,991	9,716	0	2,277	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	16,640	18,385	11,915	0	1,995	50.00
51.00	RECOVERY ROOM	1,074	2,120	1,374	0	230	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	684	382	248	0	8	53.00
54.00	RADIOLOGY-DIAGNOSTIC	27,909	14,796	9,589	0	2,247	54.00
56.00	RADIOISOTOPE	2,636	0	0	0	0	56.00
60.00	LABORATORY	23,360	7,616	4,936	0	1,441	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	1,399	0	0	0	0	63.00
66.00	PHYSICAL THERAPY	14,738	1,878	1,217	0	1,741	66.00
69.00	ELECTROCARDIOLOGY	8,836	2,296	1,488	0	1,730	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	243	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	3,130	2,176	1,410	0	330	90.00
90.01	SENIOR CARE	3,610	4,595	2,978	0	499	90.01
91.00	EMERGENCY	21,748	7,350	4,764	0	1,116	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	16,792	4,271	2,768	0	463	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	9,856	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	298,580	203,954	99,115	0	20,074	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	32	1,789	1,159	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	60,318	38,217	24,767	0	2,372	192.00
194.00	FITNESS CENTER	353	7,674	4,974	0	0	194.00
194.01	MARKETING	2,374	541	351	0	12	194.01
194.02	NEW DIRECTION	0	0	0	0	0	194.02
194.03	RESPITE	0	0	0	0	0	194.03
194.04	WELL CHILD CLINIC	1,859	6,187	4,010	0	520	194.04
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)	363,516	258,362	134,376	0	22,978	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	41,175					10.00
11.00	CAFETERIA	0	19,264				11.00
13.00	NURSING ADMINISTRATION	0	150	6,215			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	83	0	57,276		14.00
15.00	PHARMACY	0	866	0	0	62,358	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	898	0	0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	7,695	2,321	1,712	0	0	30.00
31.00	INTENSIVE CARE UNIT	4,251	1,415	1,043	0	0	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	21,374	1,840	0	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	4,934	1,387	1,023	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	108	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	719	1,461	1,078	0	0	54.00
56.00	RADIOISOTOPE	0	130	0	0	0	56.00
60.00	LABORATORY	4	1,634	0	0	0	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	PHYSICAL THERAPY	88	853	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	916	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	57,276	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	62,358	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	127	0	0	0	0	90.00
90.01	SENIOR CARE	617	184	0	0	0	90.01
91.00	EMERGENCY	1,349	1,843	1,359	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	17	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	41,175	16,089	6,215	57,276	62,358	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	3,076	0	0	0	192.00
194.00	FITNESS CENTER	0	39	0	0	0	194.00
194.01	MARKETING	0	60	0	0	0	194.01
194.02	NEW DIRECTION	0	0	0	0	0	194.02
194.03	RESPITE	0	0	0	0	0	194.03
194.04	WELL CHILD CLINIC	0	0	0	0	0	194.04
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)	41,175	19,264	6,215	57,276	62,358	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet B Part II Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		16.00	24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY						14.00
15.00	PHARMACY						15.00
16.00	MEDICAL RECORDS & LIBRARY	40,713					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,683	99,848	0	99,848		30.00
31.00	INTENSIVE CARE UNIT	1,181	37,556	0	37,556		31.00
43.00	NURSERY	0	0	0	0		43.00
44.00	SKILLED NURSING FACILITY	932	93,928	0	93,928		44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,033	188,449	0	188,449		50.00
51.00	RECOVERY ROOM	188	8,209	0	8,209		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	ANESTHESIOLOGY	400	3,112	0	3,112		53.00
54.00	RADIOLOGY-DIAGNOSTIC	7,264	376,889	0	376,889		54.00
56.00	RADIOISOTOPE	474	4,101	0	4,101		56.00
60.00	LABORATORY	5,866	89,904	0	89,904		60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	116	1,515	0	1,515		63.00
66.00	PHYSICAL THERAPY	1,345	34,664	0	34,664		66.00
69.00	ELECTROCARDIOLOGY	1,426	36,440	0	36,440		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,293	59,569	0	59,569		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	24	267	0	267		72.00
73.00	DRUGS CHARGED TO PATIENTS	10,081	72,439	0	72,439		73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	583	23,835	0	23,835		90.00
90.01	SENIOR CARE	308	19,779	0	19,779		90.01
91.00	EMERGENCY	2,834	62,086	0	62,086		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	858	32,523	0	32,523		101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	728	11,085	0	11,085		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	40,617	1,256,198	0	1,256,198		118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,634	0	5,634		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	82	237,319	0	237,319		192.00
194.00	FITNESS CENTER	0	24,441	0	24,441		194.00
194.01	MARKETING	0	4,221	0	4,221		194.01
194.02	NEW DIRECTION	0	0	0	0		194.02
194.03	RESPITE	0	0	0	0		194.03
194.04	WELL CHILD CLINIC	14	22,001	0	22,001		194.04
200.00	Cross Foot Adjustments		0	0	0		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	40,713	1,549,814	0	1,549,814		202.00

	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	NEW 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	NEW CAP REL COSTS-BLDG & FIXT	126,309					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		1,581,942				2.00
4.00	EMPLOYEE BENEFITS	2,884	12,950	15,384,639			4.00
5.00	ADMINISTRATIVE & GENERAL	7,884	469,137	1,656,029	-4,260,871	30,292,699	5.00
6.00	MAINTENANCE & REPAIRS	0	345,460	335,302	0	918,629	6.00
7.00	OPERATION OF PLANT	22,818	0	0	0	636,797	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	HOUSEKEEPING	1,920	205	304,821	0	751,005	9.00
10.00	DIETARY	4,959	2,782	142,407	0	356,947	10.00
11.00	CAFETERIA	1,538	0	378,077	0	669,165	11.00
13.00	NURSING ADMINISTRATION	480	0	154,733	0	207,555	13.00
14.00	CENTRAL SERVICES & SUPPLY	5,235	1,150	28,943	0	1,533,689	14.00
15.00	PHARMACY	3,147	1,556	639,049	0	3,066,363	15.00
16.00	MEDICAL RECORDS & LIBRARY	4,087	873	347,687	0	824,434	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	9,055	3,534	920,344	0	1,357,819	30.00
31.00	INTENSIVE CARE UNIT	1,810	8,180	561,209	0	820,157	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	6,704	10,579	636,085	0	1,017,862	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	8,222	142,823	629,889	0	1,386,668	50.00
51.00	RECOVERY ROOM	948	0	63,517	0	89,471	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	171	0	584,238	0	56,976	53.00
54.00	RADIOLOGY-DIAGNOSTIC	6,617	404,267	743,556	0	2,325,764	54.00
56.00	RADIOISOTOPE	0	1,076	75,144	0	219,666	56.00
60.00	LABORATORY	3,406	45,910	759,485	0	1,946,660	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	116,578	63.00
66.00	PHYSICAL THERAPY	840	12,697	769,177	0	1,228,200	66.00
69.00	ELECTROCARDIOLOGY	1,027	22,006	500,165	0	736,292	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	20,278	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	973	17,979	0	0	260,853	90.00
90.01	SENIOR CARE	2,055	0	138,853	0	300,843	90.01
91.00	EMERGENCY	3,287	10,948	810,153	0	1,812,305	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	1,910	0	830,756	0	1,399,363	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	0	0	409,464	0	821,358	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	101,977	1,514,112	12,419,083	-4,260,871	24,881,697	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	800	0	0	0	2,654	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	17,091	67,670	2,793,127	0	5,026,142	192.00
194.00	FITNESS CENTER	3,432	0	11,643	0	29,413	194.00
194.01	MARKETING	242	0	65,216	0	197,874	194.01
194.02	NEW DIRECTION	0	0	0	0	0	194.02
194.03	RESPITE	0	0	0	0	0	194.03
194.04	WELL CHILD CLINIC	2,767	160	95,570	0	154,919	194.04
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)	419,072	1,130,742	564,952		4,260,871	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	3.317832	0.714781	0.036722		0.140657	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			18,825		363,516	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001224		0.012000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS	115,541					6.00
7.00	OPERATION OF PLANT	22,818	92,723				7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	197,534			8.00
9.00	HOUSEKEEPING	1,920	1,920	0	473,567		9.00
10.00	DIETARY	4,959	4,959	0	0	42,458	10.00
11.00	CAFETERIA	1,538	1,538	0	0	0	11.00
13.00	NURSING ADMINISTRATION	480	480	0	480	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	5,235	5,235	0	26,175	0	14.00
15.00	PHARMACY	3,147	3,147	0	15,735	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	4,087	4,087	0	5,145	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	9,055	9,055	24,640	63,385	7,935	30.00
31.00	INTENSIVE CARE UNIT	1,810	1,810	11,691	12,670	4,383	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	6,704	6,704	54,097	46,928	22,040	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	8,222	8,222	32,469	41,110	5,088	50.00
51.00	RECOVERY ROOM	948	948	0	4,740	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	171	171	0	171	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	6,617	6,617	19,215	46,319	741	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	LABORATORY	3,406	3,406	0	29,694	4	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	PHYSICAL THERAPY	840	840	11,188	35,880	91	66.00
69.00	ELECTROCARDIOLOGY	1,027	1,027	8,653	35,649	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	973	973	0	6,811	131	90.00
90.01	SENIOR CARE	2,055	2,055	0	10,275	636	90.01
91.00	EMERGENCY	3,287	3,287	35,581	23,009	1,391	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	1,910	1,910	0	9,550	18	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	91,209	68,391	197,534	413,726	42,458	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	800	800	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	17,091	17,091	0	48,889	0	192.00
194.00	FITNESS CENTER	3,432	3,432	0	0	0	194.00
194.01	MARKETING	242	242	0	242	0	194.01
194.02	NEW DIRECTION	0	0	0	0	0	194.02
194.03	RESPITE	0	0	0	0	0	194.03
194.04	WELL CHILD CLINIC	2,767	2,767	0	10,710	0	194.04
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)	1,047,841	933,303	0	893,377	502,042	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	9.068997	10.065496	0.000000	1.886485	11.824438	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	258,362	134,376	0	22,978	41,175	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.236107	1.449220	0.000000	0.048521	0.969782	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REV)	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	572,687					11.00
13.00	NURSING ADMINISTRATION	4,459	250,525				13.00
14.00	CENTRAL SERVICES & SUPPLY	2,475	0	100			14.00
15.00	PHARMACY	25,743	0	0	100		15.00
16.00	MEDICAL RECORDS & LIBRARY	26,687	0	0	0	70,850,508	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	68,988	68,988	0	0	2,927,071	30.00
31.00	INTENSIVE CARE UNIT	42,057	42,057	0	0	2,053,863	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	54,709	0	0	0	1,620,843	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	41,241	41,241	0	0	3,536,486	50.00
51.00	RECOVERY ROOM	0	0	0	0	327,799	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	3,208	0	0	0	696,489	53.00
54.00	RADIOLOGY-DIAGNOSTIC	43,439	43,439	0	0	12,632,302	54.00
56.00	RADIOISOTOPE	3,862	0	0	0	824,593	56.00
60.00	LABORATORY	48,589	0	0	0	10,200,910	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	201,758	63.00
66.00	PHYSICAL THERAPY	25,347	0	0	0	2,339,996	66.00
69.00	ELECTROCARDIOLOGY	27,226	0	0	0	2,479,858	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	100	0	3,987,634	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	41,314	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	100	17,577,653	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	1,013,828	90.00
90.01	SENIOR CARE	5,479	0	0	0	535,545	90.01
91.00	EMERGENCY	54,800	54,800	0	0	4,927,835	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	0	0	0	1,492,183	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	0	0	0	0	1,265,703	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	478,309	250,525	100	100	70,683,663	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	91,449	0	0	0	143,363	192.00
194.00	FITNESS CENTER	1,153	0	0	0	0	194.00
194.01	MARKETING	1,776	0	0	0	0	194.01
194.02	NEW DIRECTION	0	0	0	0	0	194.02
194.03	RESPITE	0	0	0	0	0	194.03
194.04	WELL CHILD CLINIC	0	0	0	0	23,482	194.04
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)	792,717	253,011	1,902,387	3,623,202	1,065,245	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.384206	1.009923	19,023.870000	36,232.020000	0.015035	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	19,264	6,215	57,276	62,358	40,713	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.033638	0.024808	572.760000	623.580000	0.000575	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII Hospital Costs: Total Costs	RCE Disallowance	Cost: Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,144,646		2,144,646	0	2,144,646	30.00
31.00	INTENSIVE CARE UNIT	1,177,451		1,177,451	0	1,177,451	31.00
43.00	NURSERY	0		0	0	0	43.00
44.00	SKILLED NURSING FACILITY	1,738,546		1,738,546	0	1,738,546	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,028,660		2,028,660	0	2,028,660	50.00
51.00	RECOVERY ROOM	134,065		134,065	0	134,065	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	ANESTHESIOLOGY	83,498		83,498	0	83,498	53.00
54.00	RADIOLOGY-DIAGNOSTIC	3,169,580		3,169,580	0	3,169,580	54.00
56.00	RADIOISOTOPE	268,308		268,308	0	268,308	56.00
60.00	LABORATORY	2,562,335		2,562,335	0	2,562,335	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	136,009		136,009	0	136,009	63.00
66.00	PHYSICAL THERAPY	1,556,058	0	1,556,058	0	1,556,058	66.00
69.00	ELECTROCARDIOLOGY	1,001,730		1,001,730	0	1,001,730	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,962,341		1,962,341	0	1,962,341	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	23,751		23,751	0	23,751	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,887,489		3,887,489	0	3,887,489	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	345,803		345,803	0	345,803	90.00
90.01	SENIOR CARE	425,021		425,021	0	425,021	90.01
91.00	EMERGENCY	2,395,255		2,395,255	0	2,395,255	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	371,823		371,823		371,823	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	1,673,404		1,673,404		1,673,404	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	955,918		955,918		955,918	116.00
200.00	Subtotal (see instructions)	28,041,691	0	28,041,691	0	28,041,691	200.00
201.00	Less Observation Beds	371,823		371,823		371,823	201.00
202.00	Total (see instructions)	27,669,868	0	27,669,868	0	27,669,868	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I | Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Charges Inpatient	Charges Outpatient	Charges Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		Title XVIII 6.00	7.00	8.00	Hospital 9.00	Cost 10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,437,935		2,437,935			30.00
31.00	INTENSIVE CARE UNIT	2,053,863		2,053,863			31.00
43.00	NURSERY	0		0			43.00
44.00	SKILLED NURSING FACILITY	1,620,843		1,620,843			44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	378,836	3,157,649	3,536,485	0.573637	0.000000	50.00
51.00	RECOVERY ROOM	59,591	268,208	327,799	0.408985	0.000000	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	ANESTHESIOLOGY	85,710	610,780	696,490	0.119884	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	635,912	11,996,390	12,632,302	0.250911	0.000000	54.00
56.00	RADIOISOTOPE	36,422	788,171	824,593	0.325382	0.000000	56.00
60.00	LABORATORY	1,198,373	9,002,538	10,200,911	0.251187	0.000000	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	76,831	124,926	201,757	0.674123	0.000000	63.00
66.00	PHYSICAL THERAPY	449,454	1,890,542	2,339,996	0.664983	0.000000	66.00
69.00	ELECTROCARDIOLOGY	1,172,664	1,307,193	2,479,857	0.403947	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,676,190	2,311,444	3,987,634	0.492107	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	26,711	14,795	41,506	0.572231	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,533,090	14,044,563	17,577,653	0.221161	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	1,013,828	1,013,828	0.341086	0.000000	90.00
90.01	SENIOR CARE	0	535,545	535,545	0.793623	0.000000	90.01
91.00	EMERGENCY	107,327	4,820,508	4,927,835	0.486066	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	2,000	487,137	489,137	0.760161	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	0	0			101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	0	0	0			116.00
200.00	Subtotal (see instructions)	15,551,752	52,374,217	67,925,969			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	15,551,752	52,374,217	67,925,969			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I | Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	PPS Inpatient Ratio 11.00	Title XVIII	Hospital	Cost
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
43.00	NURSERY				43.00
44.00	SKILLED NURSING FACILITY				44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.000000			50.00
51.00	RECOVERY ROOM	0.000000			51.00
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
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
66.00	PHYSICAL THERAPY	0.000000			66.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0.000000			90.00
90.01	SENIOR CARE	0.000000			90.01
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
	OTHER REIMBURSABLE COST CENTERS				
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: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I | Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Title XIX Therapy Limit Adj.	Title XIX Total Costs	Hospital Costs RCE Disallowance	Hospital Costs Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,144,646		2,144,646	0	2,144,646	30.00
31.00	INTENSIVE CARE UNIT	1,177,451		1,177,451	0	1,177,451	31.00
43.00	NURSERY	0		0	0	0	43.00
44.00	SKILLED NURSING FACILITY	1,738,546		1,738,546	0	1,738,546	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,028,660		2,028,660	0	2,028,660	50.00
51.00	RECOVERY ROOM	134,065		134,065	0	134,065	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	ANESTHESIOLOGY	83,498		83,498	0	83,498	53.00
54.00	RADIOLOGY-DIAGNOSTIC	3,169,580		3,169,580	0	3,169,580	54.00
56.00	RADIOISOTOPE	268,308		268,308	0	268,308	56.00
60.00	LABORATORY	2,562,335		2,562,335	0	2,562,335	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	136,009		136,009	0	136,009	63.00
66.00	PHYSICAL THERAPY	1,556,058	0	1,556,058	0	1,556,058	66.00
69.00	ELECTROCARDIOLOGY	1,001,730		1,001,730	0	1,001,730	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,962,341		1,962,341	0	1,962,341	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	23,751		23,751	0	23,751	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,887,489		3,887,489	0	3,887,489	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	345,803		345,803	0	345,803	90.00
90.01	SENIOR CARE	425,021		425,021	0	425,021	90.01
91.00	EMERGENCY	2,395,255		2,395,255	0	2,395,255	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	371,823		371,823		371,823	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	1,673,404		1,673,404		1,673,404	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	955,918		955,918		955,918	116.00
200.00	Subtotal (see instructions)	28,041,691	0	28,041,691	0	28,041,691	200.00
201.00	Less Observation Beds	371,823		371,823		371,823	201.00
202.00	Total (see instructions)	27,669,868	0	27,669,868	0	27,669,868	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I | Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Title XIX Cost or Other Ratio	Hospital TEFRA Inpatient Ratio	PPS	
		6.00	7.00	8.00	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,437,935		2,437,935				30.00
31.00	INTENSIVE CARE UNIT	2,053,863		2,053,863				31.00
43.00	NURSERY	0		0				43.00
44.00	SKILLED NURSING FACILITY	1,620,843		1,620,843				44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	378,836	3,157,649	3,536,485	0.573637	0.000000		50.00
51.00	RECOVERY ROOM	59,591	268,208	327,799	0.408985	0.000000		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000		52.00
53.00	ANESTHESIOLOGY	85,710	610,780	696,490	0.119884	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	635,912	11,996,390	12,632,302	0.250911	0.000000		54.00
56.00	RADIOISOTOPE	36,422	788,171	824,593	0.325382	0.000000		56.00
60.00	LABORATORY	1,198,373	9,002,538	10,200,911	0.251187	0.000000		60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	76,831	124,926	201,757	0.674123	0.000000		63.00
66.00	PHYSICAL THERAPY	449,454	1,890,542	2,339,996	0.664983	0.000000		66.00
69.00	ELECTROCARDIOLOGY	1,172,664	1,307,193	2,479,857	0.403947	0.000000		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,676,190	2,311,444	3,987,634	0.492107	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	26,711	14,795	41,506	0.572231	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	3,533,090	14,044,563	17,577,653	0.221161	0.000000		73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	1,013,828	1,013,828	0.341086	0.000000		90.00
90.01	SENIOR CARE	0	535,545	535,545	0.793623	0.000000		90.01
91.00	EMERGENCY	107,327	4,820,508	4,927,835	0.486066	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	2,000	487,137	489,137	0.760161	0.000000		92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	0	0	0				101.00
	SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	0	0	0				116.00
200.00	Subtotal (see instructions)	15,551,752	52,374,217	67,925,969				200.00
201.00	Less Observation Beds							201.00
202.00	Total (see instructions)	15,551,752	52,374,217	67,925,969				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
43.00	NURSERY				43.00
44.00	SKILLED NURSING FACILITY				44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.573637			50.00
51.00	RECOVERY ROOM	0.408985			51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	ANESTHESIOLOGY	0.119884			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.250911			54.00
56.00	RADIOISOTOPE	0.325382			56.00
60.00	LABORATORY	0.251187			60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.674123			63.00
66.00	PHYSICAL THERAPY	0.664983			66.00
69.00	ELECTROCARDIOLOGY	0.403947			69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.492107			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.572231			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.221161			73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0.341086			90.00
90.01	SENIOR CARE	0.793623			90.01
91.00	EMERGENCY	0.486066			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.760161			92.00
	OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY				101.00
	SPECIAL PURPOSE COST CENTERS				
116.00	HOSPICE				116.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201 00
202.00	Total (see instructions)				202 00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part II | Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Total Cost (wkst. B, Part I, col. 26)	Title XIX Capital Cost (wkst. B, Part II col. 26)	Title XIX Operating Cost Net of Capital Cost (col. 1 - col. 2)	Hospital Capital Reduction	PPS Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,028,660	188,449	1,840,211	0	0	50.00
51.00	RECOVERY ROOM	134,065	8,209	125,856	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	83,498	3,112	80,386	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	3,169,580	376,889	2,792,691	0	0	54.00
56.00	RADIOISOTOPE	268,308	4,101	264,207	0	0	56.00
60.00	LABORATORY	2,562,335	89,904	2,472,431	0	0	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	136,009	1,515	134,494	0	0	63.00
66.00	PHYSICAL THERAPY	1,556,058	34,664	1,521,394	0	0	66.00
69.00	ELECTROCARDIOLOGY	1,001,730	36,440	965,290	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,962,341	59,569	1,902,772	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	23,751	267	23,484	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,887,489	72,439	3,815,050	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	345,803	23,835	321,968	0	0	90.00
90.01	SENIOR CARE	425,021	19,779	405,242	0	0	90.01
91.00	EMERGENCY	2,395,255	62,086	2,333,169	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	371,823	0	371,823	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	1,673,404	32,523	1,640,881	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	955,918	11,085	944,833	0	0	116.00
200.00	Subtotal (sum of lines 50 thru 199)	22,981,048	1,024,866	21,956,182	0	0	200.00
201.00	Less Observation Beds	371,823	0	371,823	0	0	201.00
202.00	Total (line 200 minus line 201)	22,609,225	1,024,866	21,584,359	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part II | Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Title XIX	Hospital	PPS	
		6.00	7.00	8.00				
	ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	2,028,660	3,536,485	0.573637				50.00
51.00	RECOVERY ROOM	134,065	327,799	0.408985				51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000				52.00
53.00	ANESTHESIOLOGY	83,498	696,490	0.119884				53.00
54.00	RADIOLOGY-DIAGNOSTIC	3,169,580	12,632,302	0.250911				54.00
56.00	RADIOISOTOPE	268,308	824,593	0.325382				56.00
60.00	LABORATORY	2,562,335	10,200,911	0.251187				60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	136,009	201,757	0.674123				63.00
66.00	PHYSICAL THERAPY	1,556,058	2,339,996	0.664983				66.00
69.00	ELECTROCARDIOLOGY	1,001,730	2,479,857	0.403947				69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,962,341	3,987,634	0.492107				71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	23,751	41,506	0.572231				72.00
73.00	DRUGS CHARGED TO PATIENTS	3,887,489	17,577,653	0.221161				73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	345,803	1,013,828	0.341086				90.00
90.01	SENIOR CARE	425,021	535,545	0.793623				90.01
91.00	EMERGENCY	2,395,255	4,927,835	0.486066				91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	371,823	489,137	0.760161				92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	1,673,404	0	0.000000				101.00
	SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	955,918	0	0.000000				116.00
200.00	Subtotal (sum of lines 50 thru 199)	22,981,048	0					200.00
201.00	Less Observation Beds	371,823	0					201.00
202.00	Total (line 200 minus line 201)	22,609,225	61,813,328					202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet D Part II Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Title XVIII Total Charges (from Wkst. C, Part I, col. 8)	Title XVIII Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Cost 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	188,449	3,536,485	0.053287	155,536	8,288	50.00
51.00	RECOVERY ROOM	8,209	327,799	0.025043	23,539	589	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	3,112	696,490	0.004468	24,480	109	53.00
54.00	RADIOLOGY-DIAGNOSTIC	376,889	12,632,302	0.029835	264,647	7,896	54.00
56.00	RADIOISOTOPE	4,101	824,593	0.004973	18,756	93	56.00
60.00	LABORATORY	89,904	10,200,911	0.008813	541,312	4,771	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	1,515	201,757	0.007509	71,008	533	63.00
66.00	PHYSICAL THERAPY	34,664	2,339,996	0.014814	63,539	941	66.00
69.00	ELECTROCARDIOLOGY	36,440	2,479,857	0.014694	305,564	4,490	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	59,569	3,987,634	0.014938	698,894	10,440	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	267	41,506	0.006433	26,711	172	72.00
73.00	DRUGS CHARGED TO PATIENTS	72,439	17,577,653	0.004121	1,634,740	6,737	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	23,835	1,013,828	0.023510	0	0	90.00
90.01	SENIOR CARE	19,779	535,545	0.036932	0	0	90.01
91.00	EMERGENCY	62,086	4,927,835	0.012599	1,349	17	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	489,137	0.000000	1,523	0	92.00
200.00	Total (lines 50-199)	981,258	61,813,328		3,831,598	45,076	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Title XVIII Non Physician Anesthetist Cost	Title XVIII Nursing School	Title XVIII Allied Health	Hospital All Other Medical Education Cost	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
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
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
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0	90.00
90.01	SENIOR CARE	0	0	0	0	0	90.01
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XVIII Total Charges (from Wkst. C, Part I, col. 8)	Title XVIII Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	3,536,485	0.000000	0.000000	155,536	50.00
51.00	RECOVERY ROOM	0	327,799	0.000000	0.000000	23,539	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	696,490	0.000000	0.000000	24,480	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	12,632,302	0.000000	0.000000	264,647	54.00
56.00	RADIOISOTOPE	0	824,593	0.000000	0.000000	18,756	56.00
60.00	LABORATORY	0	10,200,911	0.000000	0.000000	541,312	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	201,757	0.000000	0.000000	71,008	63.00
66.00	PHYSICAL THERAPY	0	2,339,996	0.000000	0.000000	63,539	66.00
69.00	ELECTROCARDIOLOGY	0	2,479,857	0.000000	0.000000	305,564	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,987,634	0.000000	0.000000	698,894	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	41,506	0.000000	0.000000	26,711	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	17,577,653	0.000000	0.000000	1,634,740	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	1,013,828	0.000000	0.000000	0	90.00
90.01	SENIOR CARE	0	535,545	0.000000	0.000000	0	90.01
91.00	EMERGENCY	0	4,927,835	0.000000	0.000000	1,349	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	489,137	0.000000	0.000000	1,523	92.00
200.00	Total (lines 50-199)	0	61,813,328			3,831,598	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Title XVIII Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Title XVIII Outpatient Program Charges	Title XVIII Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital Cost PSA Adj. Non Physician Anesthetist Cost	Hospital Cost PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
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
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0	90.00
90.01	SENIOR CARE	0	0	0	0	0	90.01
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/14/2012 10:12 am

Title XVIII | Hospital | Cost

	Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost			
		23.00	24.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0			50.00
51.00	RECOVERY ROOM	0	0			51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	ANESTHESIOLOGY	0	0			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0			54.00
56.00	RADIOISOTOPE	0	0			56.00
60.00	LABORATORY	0	0			60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
66.00	PHYSICAL THERAPY	0	0			66.00
69.00	ELECTROCARDIOLOGY	0	0			69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0			72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0			73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0	0			90.00
90.01	SENIOR CARE	0	0			90.01
91.00	EMERGENCY	0	0			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V | Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Title XVIII Hospital Charges: PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	Cost	
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.573637	0	891,910	0		50.00
51.00	RECOVERY ROOM	0.408985	0	60,717	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0		52.00
53.00	ANESTHESIOLOGY	0.119884	0	125,175	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.250911	0	3,892,363	0		54.00
56.00	RADIOISOTOPE	0.325382	0	283,972	0		56.00
60.00	LABORATORY	0.251187	0	3,430,321	0		60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.674123	0	198,147	0		63.00
66.00	PHYSICAL THERAPY	0.664983	0	665,538	0		66.00
69.00	ELECTROCARDIOLOGY	0.403947	0	613,572	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.492107	0	483,293	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.572231	0	12,831	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.221161	0	5,949,609	2,476		73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0.341086	0	0	0		90.00
90.01	SENIOR CARE	0.793623	0	420,427	0		90.01
91.00	EMERGENCY	0.486066	0	1,038,730	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.760161	0	137,783	0		92.00
200.00	Subtotal (see instructions)		0	18,204,388	2,476		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	18,204,388	2,476		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V | Date/Time Prepared: 5/14/2012 10:12 am

Title XVIII | Hospital | Cost

	Cost Center Description	Costs: PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	511,633	0		50.00
51.00	RECOVERY ROOM	0	24,832	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	15,006	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	976,637	0		54.00
56.00	RADIOISOTOPE	0	92,399	0		56.00
60.00	LABORATORY	0	861,652	0		60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	133,575	0		63.00
66.00	PHYSICAL THERAPY	0	442,571	0		66.00
69.00	ELECTROCARDIOLOGY	0	247,851	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	237,832	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	7,342	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,315,821	548		73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0	0	0		90.00
90.01	SENIOR CARE	0	333,661	0		90.01
91.00	EMERGENCY	0	504,891	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	104,737	0		92.00
200.00	Subtotal (see instructions)	0	5,810,440	548		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	5,810,440	548		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet D Part V

Component CCN: 15Z310 Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Title XVIII Charges: PPS Reimbursed Services (see instructions)	Title XVIII Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Swing Beds - SNF Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		Cost
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.573637	0	0	0		50.00
51.00	RECOVERY ROOM	0.408985	0	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0		52.00
53.00	ANESTHESIOLOGY	0.119884	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.250911	0	0	0		54.00
56.00	RADIOISOTOPE	0.325382	0	0	0		56.00
60.00	LABORATORY	0.251187	0	0	0		60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.674123	0	0	0		63.00
66.00	PHYSICAL THERAPY	0.664983	0	0	0		66.00
69.00	ELECTROCARDIOLOGY	0.403947	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.492107	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.572231	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.221161	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0.341086	0	0	0		90.00
90.01	SENIOR CARE	0.793623	0	0	0		90.01
91.00	EMERGENCY	0.486066	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.760161	0	0	0		92.00
200.00	Subtotal (see instructions)		0	0	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V

Component CCN: 15Z310 | Date/Time Prepared: 5/14/2012 10:12 am

Title XVIII | Swing Beds - SNF | Cost

	Cost Center Description	Costs: PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0		50.00
51.00	RECOVERY ROOM	0	0	0		51.00
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
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0	0	0		90.00
90.01	SENIOR CARE	0	0	0		90.01
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Subtotal (see instructions)	0	0	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310
Component CCN: 155365

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

Worksheet D Part IV
Date/Time Prepared: 5/14/2012 10:12 am

	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)	
		Title XVIII			Skilled Nursing Facility	PPS	
		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
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
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
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0	90.00
90.01	SENIOR CARE	0	0	0	0	0	90.01
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet D Part IV

Component CCN: 155365 Date/Time Prepared: 5/14/2012 10:12 am

	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	
		Title XVIII			Skilled Nursing Facility	PPS	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	3,536,485	0.000000	0.000000	0	50.00
51.00	RECOVERY ROOM	0	327,799	0.000000	0.000000	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	696,490	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	12,632,302	0.000000	0.000000	11,202	54.00
56.00	RADIOISOTOPE	0	824,593	0.000000	0.000000	0	56.00
60.00	LABORATORY	0	10,200,911	0.000000	0.000000	51,602	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	201,757	0.000000	0.000000	3,915	63.00
66.00	PHYSICAL THERAPY	0	2,339,996	0.000000	0.000000	219,897	66.00
69.00	ELECTROCARDIOLOGY	0	2,479,857	0.000000	0.000000	70,342	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,987,634	0.000000	0.000000	4,570	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	41,506	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	17,577,653	0.000000	0.000000	312,055	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	1,013,828	0.000000	0.000000	0	90.00
90.01	SENIOR CARE	0	535,545	0.000000	0.000000	0	90.01
91.00	EMERGENCY	0	4,927,835	0.000000	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	489,137	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	61,813,328			673,583	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310
Component CCN: 155365

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

Worksheet D Part IV
Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Title XVIII Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Title XVIII Outpatient Program Charges	Title XVIII Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Skilled Nursing Facility PSA Adj. Non Physician Anesthetist Cost	PPS PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
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
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0	90.00
90.01	SENIOR CARE	0	0	0	0	0	90.01
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet D Part IV
Component CCN: 155365 Date/Time Prepared: 5/14/2012 10:12 am
Title XVIII Skilled Nursing Facility PPS

	Cost Center Description	PSA Adj. Allied Health 23.00	PSA Adj. All Other Medical Education Cost 24.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0		50.00
51.00	RECOVERY ROOM	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	RADIOISOTOPE	0	0		56.00
60.00	LABORATORY	0	0		60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
66.00	PHYSICAL THERAPY	0	0		66.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	0		90.00
90.01	SENIOR CARE	0	0		90.01
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part I Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Title XIX Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS 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	99,848	3,131	96,717	1,637	59.08	30.00
31.00	INTENSIVE CARE UNIT	37,556		37,556	736	51.03	31.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	93,928		93,928	5,704	16.47	44.00
200.00	Total (lines 30-199)	231,332		228,201	8,077		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part I Date/Time Prepared: 5/14/2012 10:12 am

Title XIX ___ 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	34	2,009			30.00
31.00	INTENSIVE CARE UNIT	17	868			31.00
43.00	NURSERY	0	0			43.00
44.00	SKILLED NURSING FACILITY	0	0			44.00
200.00	Total (lines 30-199)	51	2,877			200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet D Part II Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Title XIX Total Charges (From Wkst. C, Part I, col. 8)	Title XIX Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	PPS 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	188,449	3,536,485	0.053287	6,370	339	50.00
51.00	RECOVERY ROOM	8,209	327,799	0.025043	1,100	28	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	3,112	696,490	0.004468	1,574	7	53.00
54.00	RADIOLOGY-DIAGNOSTIC	376,889	12,632,302	0.029835	41,338	1,233	54.00
56.00	RADIOISOTOPE	4,101	824,593	0.004973	0	0	56.00
60.00	LABORATORY	89,904	10,200,911	0.008813	34,756	306	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	1,515	201,757	0.007509	0	0	63.00
66.00	PHYSICAL THERAPY	34,664	2,339,996	0.014814	1,628	24	66.00
69.00	ELECTROCARDIOLOGY	36,440	2,479,857	0.014694	22,205	326	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	59,569	3,987,634	0.014938	39,860	595	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	267	41,506	0.006433	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	72,439	17,577,653	0.004121	93,204	384	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	23,835	1,013,828	0.023510	0	0	90.00
90.01	SENIOR CARE	19,779	535,545	0.036932	0	0	90.01
91.00	EMERGENCY	62,086	4,927,835	0.012599	18,909	238	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	17,871	489,137	0.036536	0	0	92.00
200.00	Total (lines 50-199)	999,129	61,813,328		260,944	3,480	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 1S1310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part III Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Nursing School	Title XIX Allied Health Cost	Title XIX All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS 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
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: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part III Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Title XIX Inpatient Program Days	Hospital Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PPS PSA Adj. Nursing School	
		6.00	7.00	8.00	9.00	11.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,637	0.00	34	0	0	30.00
31.00	INTENSIVE CARE UNIT	736	0.00	17	0	0	31.00
43.00	NURSERY	0	0.00	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	5,704	0.00	0	0	0	44.00
200.00	Total (lines 30-199)	8,077		51	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Title XIX Non Physician Anesthetist Cost	Title XIX Nursing School	Title XIX Allied Health	Hospital All Other Medical Education Cost	PPS 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
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
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
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0	90.00
90.01	SENIOR CARE	0	0	0	0	0	90.01
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XIX Total Charges (from Wkst. C, Part I, col. 8)	Title XIX Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	3,536,485	0.000000	0.000000	6,370	50.00
51.00	RECOVERY ROOM	0	327,799	0.000000	0.000000	1,100	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	696,490	0.000000	0.000000	1,574	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	12,632,302	0.000000	0.000000	41,338	54.00
56.00	RADIOISOTOPE	0	824,593	0.000000	0.000000	0	56.00
60.00	LABORATORY	0	10,200,911	0.000000	0.000000	34,756	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	201,757	0.000000	0.000000	0	63.00
66.00	PHYSICAL THERAPY	0	2,339,996	0.000000	0.000000	1,628	66.00
69.00	ELECTROCARDIOLOGY	0	2,479,857	0.000000	0.000000	22,205	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,987,634	0.000000	0.000000	39,860	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	41,506	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	17,577,653	0.000000	0.000000	93,204	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	1,013,828	0.000000	0.000000	0	90.00
90.01	SENIOR CARE	0	535,545	0.000000	0.000000	0	90.01
91.00	EMERGENCY	0	4,927,835	0.000000	0.000000	18,909	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	489,137	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	61,813,328			260,944	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Title XIX Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Title XIX Outpatient Program Charges	Title XIX Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital PSA Adj. Non Physician Anesthetist Cost	PPS PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
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
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0	90.00
90.01	SENIOR CARE	0	0	0	0	0	90.01
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	PPS	
		23.00	24.00				
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0				50.00
51.00	RECOVERY ROOM	0	0				51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00	ANESTHESIOLOGY	0	0				53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0				54.00
56.00	RADIOISOTOPE	0	0				56.00
60.00	LABORATORY	0	0				60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
66.00	PHYSICAL THERAPY	0	0				66.00
69.00	ELECTROCARDIOLOGY	0	0				69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0				73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0				90.00
90.01	SENIOR CARE	0	0				90.01
91.00	EMERGENCY	0	0				91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00	Total (lines 50-199)	0	0				200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Title XIX Charges: PPS Reimbursed Services (see instructions)	Title XIX Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Hospital: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	PPS	
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.573637	0	162,729	0		50.00
51.00	RECOVERY ROOM	0.408985	0	24,441	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0		52.00
53.00	ANESTHESIOLOGY	0.119884	0	39,011	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.250911	0	951,905	0		54.00
56.00	RADIOISOTOPE	0.325382	0	16,777	0		56.00
60.00	LABORATORY	0.251187	0	786,645	0		60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.674123	0	7,799	0		63.00
66.00	PHYSICAL THERAPY	0.664983	0	47,276	0		66.00
69.00	ELECTROCARDIOLOGY	0.403947	0	78,780	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.492107	0	217,635	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.572231	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.221161	0	648,463	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0.341086	0	100,958	0		90.00
90.01	SENIOR CARE	0.793623	0	0	0		90.01
91.00	EMERGENCY	0.486066	0	755,157	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.760161	0	32,295	0		92.00
200.00	Subtotal (see instructions)		0	3,869,871	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	3,869,871	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V | Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Title XIX Costs: PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)	Hospital	PPS
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	93,347	0		50.00
51.00	RECOVERY ROOM	0	9,996	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	4,677	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	238,843	0		54.00
56.00	RADIOISOTOPE	0	5,459	0		56.00
60.00	LABORATORY	0	197,595	0		60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	5,257	0		63.00
66.00	PHYSICAL THERAPY	0	31,438	0		66.00
69.00	ELECTROCARDIOLOGY	0	31,823	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	107,100	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	143,415	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0	34,435	0		90.00
90.01	SENIOR CARE	0	0	0		90.01
91.00	EMERGENCY	0	367,056	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	24,549	0		92.00
200.00	Subtotal (see instructions)	0	1,294,990	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	1,294,990	0		202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Title XVIII Hospital Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,738	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,637	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)	1,637	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	53	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	101	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)	590	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)	53	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,144,646	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)	67,258	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,077,388	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	2,437,935	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	2,437,935	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.852110	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)	1,489.27	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)	2,077,388	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,269.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	748,722	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)	748,722	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Title XVIII Total Inpatient Cost	Title XVIII Total Inpatient Days	Title XVIII Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Cost 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	1,177,451	736	1,599.80	434	694,313	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)	1,246,383	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,689,418	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)	67,258	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)	67,258	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)	293	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,269.02	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	371,823	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011

Worksheet D-1

Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Cost	Title XVIII Routine Cost (from line 27)	Title XVIII column 1 ÷ column 2	Hospital Total Observation Bed Cost (from line 89)	Cost 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: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1

Component CCN: 155365 | Date/Time Prepared: 5/14/2012 10:12 am

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)	5,704	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,704	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)	5,704	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)	1,262	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,738,546	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)	1,738,546	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,620,843	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,620,843	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.072618	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)	284.16	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)	1,738,546	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: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1

Component CCN: 155365 | Date/Time Prepared: 5/14/2012 10:12 am

	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			Skilled Nursing Facility	PPS	
		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)					1,738,546	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					304.79	71.00
72.00	Program routine service cost (line 9 x line 71)					384,645	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)					384,645	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)					384,645	83.00
84.00	Program inpatient ancillary services (see instructions)					264,317	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)					648,962	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: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet D-1

Component CCN: 155365 Date/Time Prepared: 5/14/2012 10:12 am

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

	Cost Center Description	Title XIX	Hospital	PPS	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,738	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,637	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)			1,637	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			53	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			101	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)			34	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			101	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			2,144,646	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)			67,258	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,077,388	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			2,437,935	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			2,437,935	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.852310	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)			1,489.27	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)			2,077,388	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,269.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			43,147	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)			43,147	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Title XIX Hospital Program Days	PPS 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	1,177,451	736	1,599.80	17	27,197	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)	82,867	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	153,211	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)	2,877	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,480	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	6,357	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	146,854	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)	293	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,269.02	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	371,823	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Cost	Title XIX Routine Cost (from line 27)	Title XIX column 1 ÷ column 2	Hospital Total Observation Bed Cost (from line 89)	PPS 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	99,848	2,077,388	0.048064	371,823	17,871	90.00
91.00	Nursing School cost	0	2,077,388	0.000000	371,823	0	91.00
92.00	Allied health cost	0	2,077,388	0.000000	371,823	0	92.00
93.00	All other Medical Education	0	2,077,388	0.000000	371,823	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011

Worksheet D-3

Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Title XVIII 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		1,000,072		30.00
31.00	INTENSIVE CARE UNIT		1,024,911		31.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.573637	155,536	89,221	50.00
51.00	RECOVERY ROOM	0.408985	23,539	9,627	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0.119884	24,480	2,935	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.250911	264,647	66,403	54.00
56.00	RADIOISOTOPE	0.325382	18,756	6,103	56.00
60.00	LABORATORY	0.251187	541,312	135,971	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.674123	71,008	47,868	63.00
66.00	PHYSICAL THERAPY	0.664983	63,539	42,252	66.00
69.00	ELECTROCARDIOLOGY	0.403947	305,564	123,432	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.492107	698,894	343,931	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.572231	26,711	15,285	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.221161	1,634,740	361,541	73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0.341086	0	0	90.00
90.01	SENIOR CARE	0.793623	0	0	90.01
91.00	EMERGENCY	0.486066	1,349	656	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.760161	1,523	1,158	92.00
200.00	Total (sum of lines 50-94 and 96-98)		3,831,598	1,246,383	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)		3,831,598		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet D-3

Component CCN: 15Z310 Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Title XVIII Ratio of Cost To Charges	Swing Beds - SNF 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		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.573637	0	0	50.00
51.00	RECOVERY ROOM	0.408985	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0.119884	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.250911	3,244	814	54.00
56.00	RADIOISOTOPE	0.325382	966	314	56.00
60.00	LABORATORY	0.251187	7,924	1,990	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.674123	1,569	1,058	63.00
66.00	PHYSICAL THERAPY	0.664983	11,033	7,337	66.00
69.00	ELECTROCARDIOLOGY	0.403947	6,542	2,643	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.492107	1,187	584	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.572231	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.221161	71,131	15,731	73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0.341086	0	0	90.00
90.01	SENIOR CARE	0.793623	0	0	90.01
91.00	EMERGENCY	0.486066	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.760161	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		103,596	30,471	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)		103,596		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet D-3

Component CCN: 155365 Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Title XVIII Ratio of Cost To Charges	Skilled Nursing Facility Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.573637	0	0	50.00
51.00	RECOVERY ROOM	0.408985	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0.119884	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.250911	11,202	2,811	54.00
56.00	RADIOISOTOPE	0.325382	0	0	56.00
60.00	LABORATORY	0.251187	51,602	12,962	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.674123	3,915	2,639	63.00
66.00	PHYSICAL THERAPY	0.664983	219,897	146,228	66.00
69.00	ELECTROCARDIOLOGY	0.403947	70,342	28,414	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.492107	4,570	2,249	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.572231	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.221161	312,055	69,014	73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0.341086	0	0	90.00
90.01	SENIOR CARE	0.793623	0	0	90.01
91.00	EMERGENCY	0.486066	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.760161	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		673,583	264,317	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)		673,583		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-3 | Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Title XIX Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		62,098		30.00
31.00	INTENSIVE CARE UNIT		43,252		31.00
43.00	NURSERY		0		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.573637	6,370	3,654	50.00
51.00	RECOVERY ROOM	0.408985	1,100	450	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0.119884	1,574	189	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.250911	41,338	10,372	54.00
56.00	RADIOISOTOPE	0.325382	0	0	56.00
60.00	LABORATORY	0.251187	34,756	8,730	60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.674123	0	0	63.00
66.00	PHYSICAL THERAPY	0.664983	1,628	1,083	66.00
69.00	ELECTROCARDIOLOGY	0.403947	22,205	8,970	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.492107	39,860	19,615	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.572231	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.221161	93,204	20,613	73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0.341086	0	0	90.00
90.01	SENIOR CARE	0.793623	0	0	90.01
91.00	EMERGENCY	0.486066	18,909	9,191	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.760161	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		260,944	82,867	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)		260,944		202.00

		Title XVIII Hospital	Cost	
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		5,810,988	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,810,988	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)		5,869,098	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)		37,125	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,940,181	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)		2,891,792	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)		2,891,792	30.00
31.00	Primary payer payments		2,662	31.00
32.00	Subtotal (line 30 minus line 31)		2,889,130	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)		487,822	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		487,822	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)		3,376,952	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)		3,376,952	40.00
41.00	Interim payments		3,213,823	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)		163,129	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: 151310	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/14/2012 10:12 am
Title XVIII	Hospital	Cost

		Overrides 1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet E Part B

Component CCN: 155365 | Date/Time Prepared: 5/14/2012 10:12 am

		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		0	12.00
12.00	Ancillary service charges		0	13.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	14.00
14.00	Total reasonable charges (sum of lines 12 and 13)			
	Customary charges		0	15.00
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	16.00
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)		0.000000	17.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0	18.00
18.00	Total customary charges (see instructions)		0	19.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	20.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	21.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	22.00
22.00	Interns and residents (see instructions)		0	23.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	24.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	25.00
25.00	Deductibles and coinsurance (for CAH, see instructions)			26.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	27.00
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	28.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	29.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	30.00
30.00	Subtotal (sum of lines 27 through 29)		0	31.00
31.00	Primary payer payments		0	32.00
32.00	Subtotal (line 30 minus line 31)			
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		0	33.00
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	34.00
34.00	Allowable bad debts (see instructions)		0	35.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	36.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	37.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			38.00
38.00	MSP-LCC reconciliation amount from PS&R		0	39.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.99
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	40.00
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		0	41.00
41.00	Interim payments		0	42.00
42.00	Tentative settlement (for contractors use only)		0	43.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		0	44.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			
	TO BE COMPLETED BY CONTRACTOR			90.00
90.00	Original outlier amount (see instructions)			91.00
91.00	Outlier reconciliation adjustment amount (see instructions)			92.00
92.00	The rate used to calculate the Time Value of Money			93.00
93.00	Time Value of Money (see instructions)			94.00
94.00	Total (sum of lines 91 and 93)			

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151310 Component CCN: 155365	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/14/2012 10:12 am
	Title XVIII	Skilled Nursing Facility	PPS

		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet E-1 Part I Date/Time Prepared: 5/14/2012 10:12 am

		Title XVIII Inpatient Part A		Hospital Part B		Cost
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,634,380		3,733,596	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	09/19/2011	409,394	09/19/2011	464,246	3.50
3.51		12/21/2011	71,093	12/21/2011	55,527	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)		-480,487		-519,773	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)		2,153,893		3,213,823	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		308,016		163,129	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,461,909		3,376,952	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: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet E-1 Part I

Component CCN: 152310 | Date/Time Prepared: 5/14/2012 10:12 am

		Title XVIII Inpatient Part A		Swing Beds - SNF Part B	Cost	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		124,236		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	12/21/2011	29,714		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)		-29,714		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)		94,522		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		3,194		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		97,716		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: 151310 Component CCN: 155365 | Period: From 01/01/2011 To 12/31/2011 | Worksheet E-1 Part I Date/Time Prepared: 5/14/2012 10:12 am

		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		313,543		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)		313,543		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)		313,543		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: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet E-2

Component CCN: 152310 Date/Time Prepared: 5/14/2012 10:12 am

		Title XVIII	Swing Beds - SNF		
			Cost		
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		67,931	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)		30,776	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		53	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)		98,707	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		98,707	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)		98,707	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		991	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)		97,716	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)		97,716	0	19.00
20.00	Interim payments		94,522	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)		3,194	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

		Title XVIII Hospital	Cost	
			1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)			
1.00	Inpatient services		2,689,418	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		2,689,418	4.00
5.00	Primary payer payments		4,709	5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)		2,711,603	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable charges			
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
	Customary charges			
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,711,603	19.00
20.00	Deductibles (exclude professional component)		294,288	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		2,417,315	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		2,417,315	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		44,594	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		44,594	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)		2,461,909	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		2,461,909	30.00
31.00	Interim payments		2,153,893	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)		308,016	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

		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)	376,491	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)	376,491	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	62,948	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Allowable reimbursable bad debts (see instructions)	0	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)	313,543	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	313,543	15.00
16.00	Interim payments	313,543	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)	0	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: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet G Date/Time Prepared: 5/14/2012 10:12 am

		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	242,905	0	0	0	1.00
2.00	Temporary investments	5,940,099	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	14,529,481	0	0	0	4.00
5.00	Other receivable	244,517	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,706,857	0	0	0	6.00
7.00	Inventory	802,304	0	0	0	7.00
8.00	Prepaid expenses	199,245	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	570,403	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	14,822,097	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	31,517,358	0	0	0	15.00
16.00	Accumulated depreciation	-25,317,951	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	6,199,407	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	663,927	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	9,522,320	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,186,247	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	31,207,751	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	706,334	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,416,244	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	310,664	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,433,242	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	2,433,242	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	28,774,509				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)	28,774,509	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	31,207,751	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-1 | Date/Time Prepared: 5/14/2012 10:12 am

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
1.00	Fund balances at beginning of period		28,247,678		0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		-137,094			2.00
3.00	Total (sum of line 1 and line 2)		28,110,584		0	3.00
4.00	Additions (credit adjustments) (specify)	663,925		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		663,925		0	10.00
11.00	Subtotal (line 3 plus line 10)		28,774,509		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		28,774,509		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-1 | Date/Time Prepared: 5/14/2012 10:12 am

		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	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		0		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet G-2 Parts Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Inpatient 1.00	Outpatient 2.00	Total 3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,437,935		2,437,935	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,620,843		1,620,843	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)	4,058,778		4,058,778	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,053,863		2,053,863	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)	2,053,863		2,053,863	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,112,641		6,112,641	17.00
18.00	Ancillary services	9,424,919	50,838,842	60,263,761	18.00
19.00	Outpatient services	0	1,549,373	1,549,373	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,492,183	1,492,183	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,265,703	1,265,703	26.00
27.00	PRO FEES	0	166,844	166,844	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	15,537,560	55,312,945	70,850,505	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		37,520,041		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	PHYSICIAN PRACTICE EXPENSE	5,930,679			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)		5,930,679		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		31,589,362		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-3 | Date/Time Prepared: 5/14/2012 10:12 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	70,850,505	1.00
2.00	Less contractual allowances and discounts on patients' accounts	38,606,015	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,244,490	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,589,362	4.00
5.00	Net income from service to patients (line 3 minus line 4)	655,128	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	625,429	24.00
24.01	PY ADJUSTMENT	597,670	24.01
24.02	INVESTMENT ACTIVITY	123,996	24.02
24.03		0	24.03
25.00	Total other income (sum of lines 6-24)	1,347,095	25.00
26.00	Total (line 5 plus line 25)	2,002,223	26.00
27.00	PRACTICE NET INCOME	2,139,317	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2,139,317	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-137,094	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet H

HHA CCN: 157061 Date/Time Prepared: 5/14/2012 10:12 am PPS

		Home Health Agency I					
		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	121,893	0	1,223	0	455,873	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	256,367	0	22,720	0	0	6.00
7.00	Physical Therapy	184,242	0	12,703	0	0	7.00
8.00	Occupational Therapy	23,956	0	1,115	0	0	8.00
9.00	Speech Pathology	0	0	225	1,746	0	9.00
10.00	Medical Social Services	217	0	125	0	0	10.00
11.00	Home Health Aide	196,619	0	26,078	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	47,079	0	9,955	0	0	22.00
23.00	WELL CHILD CLINIC	383	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	830,756	0	74,144	1,746	455,873	24.00

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

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet H
HHA CCN: 157061 Date/Time Prepared: 5/14/2012 10:12 am

		Total (sum of cols. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Home Health Agency I, Adjustments	PPS 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	578,989	0	578,989	0	578,989	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	279,087	0	279,087	0	279,087	6.00
7.00	Physical Therapy	196,945	0	196,945	0	196,945	7.00
8.00	Occupational Therapy	25,071	0	25,071	0	25,071	8.00
9.00	Speech Pathology	1,971	0	1,971	0	1,971	9.00
10.00	Medical Social Services	342	0	342	0	342	10.00
11.00	Home Health Aide	222,697	0	222,697	0	222,697	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	57,034	0	57,034	0	57,034	22.00
23.00	WELL CHILD CLINIC	383	0	383	0	383	23.00
24.00	Total (sum of lines 1-23)	1,362,519	0	1,362,519	0	1,362,519	24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011
HHA CCN: 157061

Worksheet H-1 Part I
Date/Time Prepared: 5/14/2012 10:12 am
PPS

Home Health Agency I

		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	578,989	0	0	0	0	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	279,087	0	0	0	0	6.00
7.00	Physical Therapy	196,945	0	0	0	0	7.00
8.00	Occupational Therapy	25,071	0	0	0	0	8.00
9.00	Speech Pathology	1,971	0	0	0	0	9.00
10.00	Medical Social Services	342	0	0	0	0	10.00
11.00	Home Health Aide	222,697	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	57,034	0	0	0	0	22.00
23.00	WELL CHILD CLINIC	383	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,362,519	0	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet H-1 Part I

HHA CCN: 157061 Date/Time Prepared: 5/14/2012 10:12 am

		Subtotal (cols. 0-4) 4A.00	Administrative & General 5.00	Total (cols. 4A + 5) 6.00	Home Health Agency I	PPS	
	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	578,989	578,989				5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	279,087	206,232	485,319			6.00
7.00	Physical Therapy	196,945	145,532	342,477			7.00
8.00	Occupational Therapy	25,071	18,526	43,597			8.00
9.00	Speech Pathology	1,971	1,456	3,427			9.00
10.00	Medical Social Services	342	253	595			10.00
11.00	Home Health Aide	222,697	164,562	387,259			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	57,034	42,145	99,179			22.00
23.00	WELL CHILD CLINIC	383	283	666			23.00
24.00	Total (sum of lines 1-23)	783,530		1,362,519			24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet H-1 Part II Date/Time Prepared: 5/14/2012 10:12 am

HHA CCN: 157061

Home Health Agency I

		Capital Related Costs				PPS	
		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	-578,989	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	WELL CHILD CLINIC	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-578,989	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: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet H-1 Part II

HHA CCN: 157061 Date/Time Prepared: 5/14/2012 10:12 am

		Administrative & General (ACCUM. COST) 5.00	Home Health Agency I	PPS
	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	783,530		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	279,087		6.00
7.00	Physical Therapy	196,945		7.00
8.00	Occupational Therapy	25,071		8.00
9.00	Speech Pathology	1,971		9.00
10.00	Medical Social Services	342		10.00
11.00	Home Health Aide	222,697		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	57,034		22.00
23.00	WELL CHILD CLINIC	383		23.00
24.00	Total (sum of lines 1-23)	783,530		24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	578,989		25.00
26.00	Unit Cost Multiplier	0.738949		26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet H-2 Part I
HHA CCN: 157061 Date/Time Prepared: 5/14/2012 10:12 am

			CAPITAL RELATED COSTS		Home Health Agency I	PPS	
		HHA Trial Balance (1)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		0	1.00	2.00	4.00	4A	
1.00	Administrative and General	0	6,337	0	30,507	36,844	1.00
2.00	Skilled Nursing Care	485,319	0	0	0	485,319	2.00
3.00	Physical Therapy	342,477	0	0	0	342,477	3.00
4.00	Occupational Therapy	43,597	0	0	0	43,597	4.00
5.00	Speech Pathology	3,427	0	0	0	3,427	5.00
6.00	Medical Social Services	595	0	0	0	595	6.00
7.00	Home Health Aide	387,259	0	0	0	387,259	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	99,179	0	0	0	99,179	18.00
19.00	WELL CHILD CLINIC	666	0	0	0	666	19.00
20.00	Total (sum of lines 1-19) (2)	1,362,519	6,337	0	30,507	1,399,363	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: 151310 Period: From 01/01/2011 To 12/31/2011
HHA CCN: 157061

Worksheet H-2 Part I
Date/Time Prepared: 5/14/2012 10:12 am

		Home Health Agency I				PPS	
		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
1.00	Administrative and General	5,182	17,322	19,225	0	18,016	1.00
2.00	Skilled Nursing Care	68,263	0	0	0	0	2.00
3.00	Physical Therapy	48,172	0	0	0	0	3.00
4.00	Occupational Therapy	6,132	0	0	0	0	4.00
5.00	Speech Pathology	482	0	0	0	0	5.00
6.00	Medical Social Services	84	0	0	0	0	6.00
7.00	Home Health Aide	54,471	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	13,950	0	0	0	0	18.00
19.00	WELL CHILD CLINIC	94	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	196,830	17,322	19,225	0	18,016	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: 151310 Period: From 01/01/2011 To 12/31/2011
HHA CCN: 157061

Worksheet H-2 Part I
Date/Time Prepared: 5/14/2012 10:12 am

					Home Health Agency I	PPS	
		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	213	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	WELL CHILD CLINIC	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	213	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011
HHA CCN: 157061

Worksheet H-2 Part I
Date/Time Prepared: 5/14/2012 10:12 am

		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Home Health Agency I Subtotal	Allocated HHA A&G (see Part II)	PPS
		16.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	22,435	119,237	0	119,237		1.00
2.00	Skilled Nursing Care	0	553,582	0	553,582	42,472	2.00
3.00	Physical Therapy	0	390,649	0	390,649	29,971	3.00
4.00	Occupational Therapy	0	49,729	0	49,729	3,815	4.00
5.00	Speech Pathology	0	3,909	0	3,909	300	5.00
6.00	Medical Social Services	0	679	0	679	52	6.00
7.00	Home Health Aide	0	441,730	0	441,730	33,890	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	113,129	0	113,129	8,679	18.00
19.00	WELL CHILD CLINIC	0	760	0	760	58	19.00
20.00	Total (sum of lines 1-19) (2)	22,435	1,673,404	0	1,673,404	119,237	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.					0.076721	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: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet H-2 Part I

HHA CCN: 157061 | Date/Time Prepared: 5/14/2012 10:12 am

Home Health Agency I | PPS

		Total HHA Costs		
		28.00		
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	596,054		2.00
3.00	Physical Therapy	420,620		3.00
4.00	Occupational Therapy	53,544		4.00
5.00	Speech Pathology	4,209		5.00
6.00	Medical Social Services	731		6.00
7.00	Home Health Aide	475,620		7.00
8.00	Supplies (see instructions)	0		8.00
9.00	Drugs	0		9.00
10.00	DME	0		10.00
11.00	Home Dialysis Aide Services	0		11.00
12.00	Respiratory Therapy	0		12.00
13.00	Private Duty Nursing	0		13.00
14.00	Clinic	0		14.00
15.00	Health Promotion Activities	0		15.00
16.00	Day Care Program	0		16.00
17.00	Home Delivered Meals Program	0		17.00
18.00	Homemaker Service	121,808		18.00
19.00	WELL CHILD CLINIC	818		19.00
20.00	Total (sum of lines 1-19) (2)	1,673,404		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 STATISTICAL BASIS

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet H-2 Part II

HHA CCN: 157061 Date/Time Prepared: 5/14/2012 10:12 am

		CAPITAL RELATED COSTS			Home Health Agency I	PPS	
		NEW BLDG & FIXT (SQUARE FEET)	NEW 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	1,910	0	830,756	0	36,844	1.00
2.00	Skilled Nursing Care	0	0	0	0	485,319	2.00
3.00	Physical Therapy	0	0	0	0	342,477	3.00
4.00	Occupational Therapy	0	0	0	0	43,597	4.00
5.00	Speech Pathology	0	0	0	0	3,427	5.00
6.00	Medical Social Services	0	0	0	0	595	6.00
7.00	Home Health Aide	0	0	0	0	387,259	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	99,179	18.00
19.00	WELL CHILD CLINIC	0	0	0	0	666	19.00
20.00	Total (sum of lines 1-19)	1,910	0	830,756		1,399,363	20.00
21.00	Total cost to be allocated	6,337	0	30,507		196,830	21.00
22.00	Unit cost multiplier	3.317801	0.000000	0.036722		0.140657	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151310
HHA CCN: 157061

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

Worksheet H-2 Part II
Date/Time Prepared: 5/14/2012 10:12 am

		Home Health Agency I				PPS	
		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	1,910	1,910	0	9,550	18	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	WELL CHILD CLINIC	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,910	1,910	0	9,550	18	20.00
21.00	Total cost to be allocated	17,322	19,225	0	18,016	213	21.00
22.00	Unit cost multiplier	9.069110	10.065445	0.000000	1.886492	11.833333	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet H-2 Part II Date/Time Prepared: 5/14/2012 10:12 am

HHA CCN: 157061

Home Health Agency I PPS

		CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REV)	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	1,492,183	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	WELL CHILD CLINIC	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	0	0	1,492,183	20.00
21.00	Total cost to be allocated	0	0	0	0	22,435	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.015035	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet H-3 Parts I-II Date/Time Prepared: 5/14/2012 10:12 am

HHA CCN: 157061

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	2.00	596,054		596,054	4,180	1.00
2.00	Physical Therapy	3.00	420,620	0	420,620	2,170	2.00
3.00	Occupational Therapy	4.00	53,544	0	53,544	384	3.00
4.00	Speech Pathology	5.00	4,209	0	4,209	25	4.00
5.00	Medical Social Services	6.00	731		731	13	5.00
6.00	Home Health Aide	7.00	475,620		475,620	7,534	6.00
7.00	Total (sum of lines 1-6)		1,550,778	0	1,550,778	14,306	7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits 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		15999	551	531		8.00
9.00	Physical Therapy		15999	495	435		9.00
10.00	Occupational Therapy		15999	86	68		10.00
11.00	Speech Pathology		15999	7	0		11.00
12.00	Medical Social Services		15999	0	3		12.00
13.00	Home Health Aide		15999	79	759		13.00
14.00	Total (sum of lines 8-13)			1,218	1,796		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	257	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	0.664983	0	0	1.00
2.00	Occupational Therapy					2.00
3.00	Speech Pathology					3.00
4.00	Cost of Medical Supplies	71.00	0.492107	0	0	4.00
5.00	Cost of Drugs	73.00	0.221161	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet H-3 Parts I-II
HHA CCN: 157061 | Date/Time Prepared: 5/14/2012 10:12 am

Title XVIII | Home Health Agency I | PPS

	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	142.60	551	531			1.00
2.00	Physical Therapy	193.83	495	435			2.00
3.00	Occupational Therapy	139.44	86	68			3.00
4.00	Speech Pathology	168.36	7	0			4.00
5.00	Medical Social Services	56.23	0	3			5.00
6.00	Home Health Aide	63.13	79	759			6.00
7.00	Total (sum of lines 1-6)		1,218	1,796			7.00
	Cost Center Description	5.00	6.00	7.00	8.00	9.00	
	Limitation Cost Computation						
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00

Program Covered Charges

	Cost Center Description	Ratio (col. 3 ÷ col. 4)	Part A	Part B Not Subject to Deductibles & Coinsurance	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	0	108	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: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet H-3 Parts I-II
HHA CCN: 157061 | Date/Time Prepared: 5/14/2012 10:12 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	Cost of Services: Part A	Part B: Not Subject to Deductibles & Coinsurance	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	78,573	75,721		154,294	1.00
2.00	Physical Therapy	95,946	84,316		180,262	2.00
3.00	Occupational Therapy	11,992	9,482		21,474	3.00
4.00	Speech Pathology	1,179	0		1,179	4.00
5.00	Medical Social Services	0	169		169	5.00
6.00	Home Health Aide	4,987	47,916		52,903	6.00
7.00	Total (sum of lines 1-6)	192,677	217,604		410,281	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	Part B: Not Subject to Deductibles & Coinsurance	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: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet H-4 Part I-II

HHA CCN: 157061 Date/Time Prepared: 5/14/2012 10:12 am

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 1.00	Part B Services 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	217,237	204,556	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	1,205	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	3,269	2,762	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	2,443	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	308	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)	220,506	211,274	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	220,506	211,274	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	220,506	211,274	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)	220,506	211,274	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	220,506	211,274	31.00
32.00	Interim payments (see instructions)	220,506	211,274	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: 151310
HHA CCN: 157061

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

Worksheet H-5

Date/Time Prepared: 5/14/2012 10:12 am

		Home Health Agency I				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		220,506		211,274		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)		220,506		211,274		4.00
	TO BE COMPLETED BY CONTRACTOR						5.00
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)						
	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)		220,506		211,274		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: 151310 Period: From 01/01/2011 To 12/31/2011
Hospice CCN: 151545
Worksheet K
Date/Time Prepared: 5/14/2012 10:12 am

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	409,464	160,185	30,750	0	10,633	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	27,500	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	102,558	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	62,581	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	2,651	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)	409,464	160,185	30,750	0	205,923	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151310 Hospice CCN: 151545 Period: From 01/01/2011 To 12/31/2011 Worksheet K Date/Time Prepared: 5/14/2012 10:12 am

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 + col. 7)	Hospice I Adjustments	Total (col. 8 + col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	611,032	0	611,032	0	611,032	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	27,500	0	27,500	0	27,500	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	102,558	0	102,558	0	102,558	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	62,581	0	62,581	0	62,581	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	2,651	0	2,651	0	2,651	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)	806,322	0	806,322	0	806,322	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet K-1

Hospice CCN: 151545 Date/Time Prepared: 5/14/2012 10:12 am

		Administrator	Director	Social Services	Hospice I 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	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet K-1

Hospice CCN: 151545 Date/Time Prepared: 5/14/2012 10:12 am

		Total Therapists	Aides	All-Other	Hospice I 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	409,464	409,464	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	0	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	409,464	409,464	39.00

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet K-2

Hospice CCN: 151545 | Date/Time Prepared: 5/14/2012 10:12 am

		Administrator	Director	Social Services	Hospice 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	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet K-2

Hospice CCN: 151545 Date/Time Prepared: 5/14/2012 10:12 am

		Total Therapists	Aides	All-Other	Hospice T 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	160,185	160,185	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	0	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	160,185	160,185	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet K-4 Part I

Hospice CCN: 151545 | Date/Time Prepared: 5/14/2012 10:12 am

			Hospice I				
			CAPITAL RELATED COST				
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
		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	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	611,032	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	27,500	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	102,558	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	62,581	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	2,651	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)	806,322	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151310 Hospice CCN: 151545 Period: From 01/01/2011 To 12/31/2011 Worksheet K-4 Part I Date/Time Prepared: 5/14/2012 10:12 am

		VOLUNTEER SERVICES COORDINATOR 5.00	SUBTOTAL (cols. 0 - 5) 5A	ADMINISTRATIVE & GENERAL 6.00	Hospice I TOTAL (col. 5A + col. 6) 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	611,032			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	27,500	86,043	113,543	9.00
10.00	Nursing Care	0	0	0	0	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	102,558	320,888	423,446	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	62,581	195,806	258,387	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	2,651	8,295	10,946	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	195,290	611,032	806,322	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151310 | Period: From 01/01/2011 To 12/31/2011 | Worksheet K-4 Part II

Hospice CCN: 151545 | Date/Time Prepared: 5/14/2012 10:12 am

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	0		4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0	0	0	0	39.00
40.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	40.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet K-4 Part II
Hospice CCN: 151545 Date/Time Prepared: 5/14/2012 10:12 am

Hospice I

		RECONCILIATION 6A	ADMINISTRATIVE & GENERAL (ACC. COST) 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	-611,032	195,290	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	27,500	9.00
10.00	Nursing Care	0	0	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	102,558	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	62,581	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	2,651	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)		611,032	39 00
40.00	Unit Cost Multiplier		3.128844	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet K-5 Part I

Hospice CCN: 151545 Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		0	1.00	2.00	4.00	4A	
1.00	Administrative and General		0	0	15,036	15,036	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	113,543	0	0	0	113,543	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	423,446	0	0	0	423,446	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	258,387	0	0	0	258,387	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	10,946	0	0	0	10,946	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)	806,322	0	0	15,036	821,358	34.00
35.00	Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310
Hospice CCN: 151545

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

Worksheet K-5 Part I
Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	Hospice I LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
1.00	Administrative and General	2,115	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	15,971	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	59,560	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	36,344	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	1,540	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)	115,530	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310 Hospice CCN: 151545 | Period: From 01/01/2011 To 12/31/2011 | Worksheet K-5 Part I Date/Time Prepared: 5/14/2012 10:12 am

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310 Hospice CCN: 151545 Period: From 01/01/2011 To 12/31/2011 Worksheet K-5 Part I Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Hospice I Subtotal (cols. 24 + 25)	Allocated Hospice A&G (See Part II)	
		16.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	19,030	36,181				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	129,514	0	129,514	5,095	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	483,006	0	483,006	19,001	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	294,731	0	294,731	11,594	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	12,486	0	12,486	491	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)	19,030	955,918	0	955,918		34.00
35.00	Unit Cost Multiplier (see instructions)					0.039338	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet K-5 Part I

Hospice CCN: 151545 Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Total Hospice Costs (cols. 26 + 27)	Hospice I	
		28.00		
1.00	Administrative and General			1.00
2.00	Inpatient - General Care	0		2.00
3.00	Inpatient - Respite Care	0		3.00
4.00	Physician Services	134,609		4.00
5.00	Nursing Care	0		5.00
6.00	Nursing Care-Continuous Home Care	0		6.00
7.00	Physical Therapy	0		7.00
8.00	Occupational Therapy	0		8.00
9.00	Speech/ Language Pathology	0		9.00
10.00	Medical Social Services	0		10.00
11.00	Spiritual Counseling	0		11.00
12.00	Dietary Counseling	0		12.00
13.00	Counseling - Other	0		13.00
14.00	Home Health Aide and Homemaker	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0		15.00
16.00	Other	0		16.00
17.00	Drugs, Biological and Infusion Therapy	502,007		17.00
18.00	Analgesics	0		18.00
19.00	Sedatives / Hypnotics	0		19.00
20.00	Other - Specify	0		20.00
21.00	Durable Medical Equipment/Oxygen	306,325		21.00
22.00	Patient Transportation	0		22.00
23.00	Imaging Services	0		23.00
24.00	Labs and Diagnostics	0		24.00
25.00	Medical Supplies	12,977		25.00
26.00	Outpatient Services (including E/R Dept.)	0		26.00
27.00	Radiation Therapy	0		27.00
28.00	Chemotherapy	0		28.00
29.00	Other	0		29.00
30.00	Bereavement Program Costs	0		30.00
31.00	Volunteer Program Costs	0		31.00
32.00	Fundraising	0		32.00
33.00	Other Program Costs	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	955,918		34.00
35.00	Unit Cost Multiplier (see instructions)			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151310 Period: From 01/01/2011
Hospice CCN: 151545 To 12/31/2011

Worksheet K-5 Part II
Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Hospice I Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
1.00	Administrative and General	0	0	409,464	0	15,036	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	113,543	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	423,446	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	258,387	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	10,946	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	409,464		821,358	34.00
35.00	Total cost to be allocated	0	0	15,036		115,530	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.036721		0.140657	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151310 Period: From 01/01/2011
Hospice CCN: 151545 To 12/31/2011

Worksheet K-5
Part II
Date/Time Prepared:
5/14/2012 10:12 am

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151310 Period: From 01/01/2011
Hospice CCN: 151545 To 12/31/2011

Worksheet K-5
Part II
Date/Time Prepared:
5/14/2012 10:12 am

Hospice I

	Cost Center Description	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REV)	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	1,265,703	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	1,265,703	34.00
35.00	Total cost to be allocated	0	0	0	0	19,030	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000	0.015035	36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet K-5 Part III

Hospice CCN: 151545 Date/Time Prepared: 5/14/2012 10:12 am

	Cost Center Description	Wkst. C, Part 1, col. 11 line	Cost to Charge Ratio	Hospice I 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	0.664983	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	0.221161	102,558	22,682	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.251187	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.492107	2,651	1,305	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	SLEEP LAB	76.00				10.00
11.00	Totals (sum of lines 1-10)				23,987	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 151310 Period: From 01/01/2011 To 12/31/2011 Worksheet K-6

Hospice CCN: 151545 Date/Time Prepared: 5/14/2012 10:12 am

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				979,905	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				8,636	2.00
3.00	Average cost per diem (line 1 divided by line 2)				113.47	3.00
4.00	Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)	7,941				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	901,065				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		323			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		36,651			7.00
8.00	Upduplicated 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)			372		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			42,211		13.00