

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: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet 5 Parts I-III Date/Time Prepared: 1/24/2012 1:07 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date:	Time:
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WHITE COUNTY MEMORIAL HOSPITAL for the cost reporting period beginning 01/01/2011 and ending 06/30/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	104,880	-103,980	0	-71,589	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	79,333	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 Skilled Nursing Facility	0	0	0	0	0	7.00
8.00 Nursing Facility	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	-1	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	184,212	-103,980	0	-71,589	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/24/2012 1:07 pm		
1.00		2.00		3.00		4.00		

Hospital and Hospital Health Care Complex Address:									
1.00	Street: 720 SOUTH SIXTH STREET			PO Box:					1.00
2.00	City: MONTICELLO			State: IN	Zip Code: 47960	County: WHITE			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	WHITE COUNTY MEMORIAL HOSPITAL	151312	15	1	07/01/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	WHITE COUNTY MEMORIAL HOSPITAL	152312	15		02/16/1990	N	O	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HOME CARE OF WHITE COUNTY	157514	15		03/01/1997	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									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:	To:		
						1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2011	06/30/2011	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.					3		N		23.00

	In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00	0	0	0	0	0	0	24.00
25.00	0	0	0	0	0	0	25.00

							1.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.							26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.							27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0	35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/24/2012 1:07 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00	
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151312

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

Worksheet S-2
Part I
Date/Time Prepared:
1/24/2012 1:07 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1 the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00	
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
				1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00	
						1.00	2.00	3.00
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.						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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/24/2012 1:07 pm
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		1.00	
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TEFRA Providers

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

	V	XIX
	1.00	2.00

Title V or XIX Inpatient Services

90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	Y	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		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

	Physical	Occupational	Speech	Respiratory		
	1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	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.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.	250,000	5,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00

Transplant Center Information

125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
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

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			1.00		2.00			
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00		
All Providers								
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)					N	140.00	
	1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00		
142.00	Street:	PO Box:				142.00		
143.00	City:	State:		Zip Code:		143.00		
			1.00					
144.00	Are provider based physicians' costs included in worksheet A?					Y	144.00	
145.00	If costs for renal services are claimed on worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.					N	145.00	
			1.00		2.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N	146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00	
			Part A		Part B			
			1.00		2.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital		N		N	155.00		
156.00	Subprovider - IPF		N		N	156.00		
157.00	Subprovider - IRF		N		N	157.00		
158.00	Subprovider - Other		N		N	158.00		
159.00	SNF		N		N	159.00		
160.00	HHA		N		N	160.00		
161.00	CMHC				N	161.00		
					1.00			
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0.00	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: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/24/2012 1:07 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "v" for voluntary or "i" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	02/01/2012
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		
		Y/N 1.00	Legal Oper. 2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			15.00
		Part A		
	Description	Y/N	Date	
	0	1.00	2.00	
PS&R Data				
16.00	was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		16.00
17.00	was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	07/22/2011	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/24/2012 1:07 pm
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		Part A		
Description		Y/N	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.	Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	Y		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/24/2012 1:07 pm
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		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		16.00
17.00	was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	07/22/2011	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: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet S-3 Part I Date/Time Prepared: 1/24/2012 1:07 pm
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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	24	8,760	42,312.00	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)		24	8,760	42,312.00	7.00
8.00	INTENSIVE CARE UNIT	31.00	1	365	1,632.00	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	43,944.00	14.00
15.00	CAH visits					15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY	101.00				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00	Total (sum of lines 14-26)		25			27.00
28.00	Observation Bed Days					28.00
29.00	Ambulance Trips					29.00
30.00	Employee discount days (see instruction)					30.00
31.00	Employee discount days - IRF					31.00
32.00	Labor & delivery days (see instructions)					32.00
33.00	LTCH non-covered days					33.00

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	1,065	107	1,763		1.00
2.00 HMO		0	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	579	0	604		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	60		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,644	107	2,427		7.00
8.00 INTENSIVE CARE UNIT	0	36	0	68		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		179	257		13.00
14.00 Total (see instructions)	0	1,680	286	2,752		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	2,064	0	3,534		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	0		0	0		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: 151312

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

Worksheet S-3
Part I
Date/Time Prepared:
1/24/2012 1:07 pm

Cost Center Description	Full Time Equivalents			Discharges	Title XVIII	
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	9.00	10.00	11.00	12.00	13.00	
2.00 HMO				0	297	1.00
3.00 HMO IPF					0	2.00
4.00 HMO IRF						3.00
5.00 Hospital Adults & Peds. Swing Bed SNF						4.00
6.00 Hospital Adults & Peds. Swing Bed NF						5.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						6.00
8.00 INTENSIVE CARE UNIT						7.00
9.00 CORONARY CARE UNIT						8.00
10.00 BURN INTENSIVE CARE UNIT						9.00
11.00 SURGICAL INTENSIVE CARE UNIT						10.00
12.00 OTHER SPECIAL CARE (SPECIFY)						11.00
13.00 NURSERY						12.00
14.00 Total (see instructions)	0.00	222.69	0.00	0	297	13.00
15.00 CAH visits						14.00
16.00 SUBPROVIDER - IPF						15.00
17.00 SUBPROVIDER - IRF						16.00
18.00 SUBPROVIDER						17.00
19.00 SKILLED NURSING FACILITY						18.00
20.00 NURSING FACILITY						19.00
21.00 OTHER LONG TERM CARE						20.00
22.00 HOME HEALTH AGENCY	0.00	10.39	0.00			21.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						22.00
24.00 HOSPICE						23.00
25.00 CMHC - CMHC						24.00
26.00 RURAL HEALTH CLINIC						25.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.00
27.00 Total (sum of lines 14-26)	0.00	233.08	0.00			26.25
28.00 Observation Bed Days						27.00
29.00 Ambulance Trips						28.00
30.00 Employee discount days (see instruction)						29.00
31.00 Employee discount days - IRF						30.00
32.00 Labor & delivery days (see instructions)						31.00
33.00 LTCH non-covered days						32.00

Cost Center Description	Discharges		
	Title XIX	Total All Patients	
	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	43	560	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)	43	560	14.00
15.00 CAH visits			15.00
16.00 SUBPROVIDER - IPF			16.00
17.00 SUBPROVIDER - IRF			17.00
18.00 SUBPROVIDER			18.00
19.00 SKILLED NURSING FACILITY			19.00
20.00 NURSING FACILITY			20.00
21.00 OTHER LONG TERM CARE			21.00
22.00 HOME HEALTH AGENCY			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)			23.00
24.00 HOSPICE			24.00
25.00 CMHC - CMHC			25.00
26.00 RURAL HEALTH CLINIC			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER			26.25
27.00 Total (sum of lines 14-26)			27.00
28.00 Observation Bed Days			28.00
29.00 Ambulance Trips			29.00
30.00 Employee discount days (see instruction)			30.00
31.00 Employee discount days - IRF			31.00
32.00 Labor & delivery days (see instructions)			32.00
33.00 LTCH non-covered days			33.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet S-4
		Component CCN: 157514		Date/Time Prepared: 1/24/2012 1:07 pm
			Home Health Agency I	PPS

					1.00	
0.00	County	WHITE				0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	Other 4.00	Total 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	80.00	0.00	0.00	0.00	2.00

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

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

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

		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)
		without outliers	with Outliers			
		1.00	2.00	3.00	4.00	5.00

PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	780	0	23	0	803	21.00
22.00	Skilled Nursing Visit Charges	74,880	0	2,208	0	77,088	22.00
23.00	Physical Therapy Visits	701	0	10	6	717	23.00
24.00	Physical Therapy Visit Charges	75,708	0	1,080	648	77,436	24.00
25.00	Occupational Therapy Visits	10	0	0	0	10	25.00
26.00	Occupational Therapy Visit Charges	1,090	0	0	0	1,090	26.00
27.00	Speech Pathology Visits	1	0	0	0	1	27.00
28.00	Speech Pathology Visit Charges	112	0	0	0	112	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	531	0	2	0	533	31.00
32.00	Home Health Aide Visit Charges	26,550	0	100	0	26,650	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,023	0	35	6	2,064	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)	178,340	0	3,388	648	182,376	35.00
36.00	Total Number of Episodes (standard/non outlier)	91		10	1	102	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	897	0	6	0	903	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet S-10 Date/Time Prepared: 1/24/2012 1:07 pm
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.446604	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		0	6.00
7.00	Medicaid cost (line 1 times line 6)		0	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
		Uninsured patients	Insured patients	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	0	0	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	0	0	0
				1.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		0	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		264,419	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		-264,419	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		-118,091	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		-118,091	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		-118,091	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151312

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

Worksheet A

Date/Time Prepared:
1/24/2012 1:07 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT		81,579	81,579	0	81,579	1.00
1.01 CAP REL COSTS-BLDG & FIXT-HOSP		1,969,545	1,969,545	0	1,969,545	1.01
1.02 CAP REL COSTS-BLDG & FIXT-TLMAB		462,345	462,345	0	462,345	1.02
4.00 EMPLOYEE BENEFITS	34,139	1,029,784	1,063,923	0	1,063,923	4.00
5.00 ADMINISTRATIVE & GENERAL	677,157	829,213	1,506,370	0	1,506,370	5.00
7.00 OPERATION OF PLANT	85,726	0	85,726	0	85,726	7.00
7.01 OPERATION OF PLANT-HOSPITAL	0	283,020	283,020	0	283,020	7.01
7.02 OPERATION OF PLANT-TLMAB	0	79,940	79,940	0	79,940	7.02
8.00 LAUNDRY & LINEN SERVICE	0	55,155	55,155	0	55,155	8.00
9.00 HOUSEKEEPING	138,212	45,639	183,851	0	183,851	9.00
10.00 DIETARY	238,817	153,448	392,265	-137,367	254,898	10.00
11.00 CAFETERIA	0	0	0	137,367	137,367	11.00
13.00 NURSING ADMINISTRATION	280,071	33,252	313,323	0	313,323	13.00
14.00 CENTRAL SERVICES & SUPPLY	37,110	26,628	63,738	0	63,738	14.00
15.00 PHARMACY	68,438	934,598	1,003,036	0	1,003,036	15.00
16.00 MEDICAL RECORDS & LIBRARY	93,464	17,384	110,848	0	110,848	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	624,205	263,671	887,876	-50,747	837,129	30.00
31.00 INTENSIVE CARE UNIT	65,827	20,537	86,364	0	86,364	31.00
43.00 NURSERY	60,589	6,534	67,123	-12,043	55,080	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	334,813	610,699	945,512	-4,379	941,133	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	62,790	62,790	52.00
54.00 RADIOLOGY-DIAGNOSTIC	204,497	570,490	774,987	0	774,987	54.00
55.00 RADIOLOGY-THERAPEUTIC	27,051	79,447	106,498	0	106,498	55.00
56.00 RADIOISOTOPE	78,235	152,619	230,854	0	230,854	56.00
57.00 CT SCAN	78,135	255,787	333,922	0	333,922	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	56,083	215,625	271,708	0	271,708	58.00
60.00 LABORATORY	290,552	467,502	758,054	0	758,054	60.00
66.00 PHYSICAL THERAPY	146,035	13,188	159,223	0	159,223	66.00
67.00 OCCUPATIONAL THERAPY	39,623	303	39,926	0	39,926	67.00
68.00 SPEECH PATHOLOGY	37,101	2,944	40,045	0	40,045	68.00
69.00 ELECTROCARDIOLOGY	12,045	23,010	35,055	0	35,055	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,379	4,379	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	0	0	0	0	0	76.00
76.01 ONCOLOGY	51,164	50,499	101,663	0	101,663	76.01
76.02 CARDIOPULMONARY	169,259	36,110	205,369	0	205,369	76.02
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	43,718	8,220	51,938	0	51,938	90.00
91.00 EMERGENCY	438,815	446,322	885,137	0	885,137	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01 OBSERVATION BEDS (DISTINCT PART)	72,031	2,914	74,945	0	74,945	92.01
OTHER REIMBURSABLE COST CENTERS						
96.00 DURABLE MEDICAL EQUIP-RENTED	40,988	31,802	72,790	0	72,790	96.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00 HOME HEALTH AGENCY	197,213	49,111	246,324	0	246,324	101.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	4,721,113	9,308,864	14,029,977	0	14,029,977	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 PHYSICIANS' PRIVATE OFFICES	201,476	70,032	271,508	0	271,508	192.01
192.02 PHYSICIANS' PRIVATE OFFICES	0	1,152	1,152	0	1,152	192.02
192.03 PHYSICIANS' PRIVATE OFFICES	20,343	51,454	71,797	0	71,797	192.03
194.00 OCCUPATIONAL MEDICINE	0	4,863	4,863	0	4,863	194.00
194.01 VENDING ROOM	0	0	0	0	0	194.01
200.00 TOTAL (SUM OF LINES 118-199)	4,942,932	9,436,365	14,379,297	0	14,379,297	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151312

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

worksheet A
Date/Time Prepared:
1/24/2012 1:07 pm

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	81,579	1.00
1.01	CAP REL COSTS-BLDG & FIXT-HOSP	15,396	1,984,941	1.01
1.02	CAP REL COSTS-BLDG & FIXT-TLMAB	-8,411	453,934	1.02
4.00	EMPLOYEE BENEFITS	-20,362	1,043,561	4.00
5.00	ADMINISTRATIVE & GENERAL	-62,150	1,444,220	5.00
7.00	OPERATION OF PLANT	0	85,726	7.00
7.01	OPERATION OF PLANT-HOSPITAL	0	283,020	7.01
7.02	OPERATION OF PLANT-TLMAB	0	79,940	7.02
8.00	LAUNDRY & LINEN SERVICE	0	55,155	8.00
9.00	HOUSEKEEPING	0	183,851	9.00
10.00	DIETARY	-114,800	140,098	10.00
11.00	CAFETERIA	-47,174	90,193	11.00
13.00	NURSING ADMINISTRATION	0	313,323	13.00
14.00	CENTRAL SERVICES & SUPPLY	-42,003	21,735	14.00
15.00	PHARMACY	-30,278	972,758	15.00
16.00	MEDICAL RECORDS & LIBRARY	-60	110,788	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-137,214	699,915	30.00
31.00	INTENSIVE CARE UNIT	0	86,364	31.00
43.00	NURSERY	0	55,080	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-358,841	582,292	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	62,790	52.00
54.00	RADIOLOGY-DIAGNOSTIC	-350,719	424,268	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	106,498	55.00
56.00	RADIOISOTOPE	0	230,854	56.00
57.00	CT SCAN	-120,600	213,322	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	271,708	58.00
60.00	LABORATORY	-11,760	746,294	60.00
66.00	PHYSICAL THERAPY	0	159,223	66.00
67.00	OCCUPATIONAL THERAPY	0	39,926	67.00
68.00	SPEECH PATHOLOGY	0	40,045	68.00
69.00	ELECTROCARDIOLOGY	0	35,055	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	4,379	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00		0	0	76.00
76.01	ONCOLOGY	-37,500	64,163	76.01
76.02	CARDIOPULMONARY	-2,611	202,758	76.02
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	51,938	90.00
91.00	EMERGENCY	-1,690	883,447	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	0	74,945	92.01
OTHER REIMBURSABLE COST CENTERS				
96.00	DURABLE MEDICAL EQUIP-RENTED	0	72,790	96.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
101.00	HOME HEALTH AGENCY	0	246,324	101.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,330,777	12,699,200	118.00
NONREIMBURSABLE COST CENTERS				
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	PHYSICIANS' PRIVATE OFFICES	0	271,508	192.01
192.02	PHYSICIANS' PRIVATE OFFICES	0	1,152	192.02
192.03	PHYSICIANS' PRIVATE OFFICES	0	71,797	192.03
194.00	OCCUPATIONAL MEDICINE	0	4,863	194.00
194.01	VENDING ROOM	0	0	194.01
200.00	TOTAL (SUM OF LINES 118-199)	-1,330,777	13,048,520	200.00

RECLASSIFICATIONS

Provider CCN: 151312

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

worksheet A-6

Date/Time Prepared:
1/24/2012 1:07 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	81,802	55,565	1.00
	TOTALS		81,802	55,565	
B - DEFAULT					
1.00	NURSERY	43.00	0	5,135	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	49,488	13,302	2.00
	TOTALS		49,488	18,437	
C - IMPLANTABLE DEVICE					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,379	1.00
	TOTALS		0	4,379	
500.00	Grand Total: Increases		131,290	78,381	500.00

RECLASSIFICATIONS

Provider CCN: 151312

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

Worksheet A-6

Date/Time Prepared:
1/24/2012 1:07 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA RECLASS							
1.00	DIETARY	10.00	81,802	55,565	0		1.00
	TOTALS		81,802	55,565			
B - DEFAULT							
1.00	ADULTS & PEDIATRICS	30.00	32,310	18,437	0		1.00
2.00	NURSERY	43.00	17,178	0	0		2.00
	TOTALS		49,488	18,437			
C - IMPLANTABLE DEVICE							
1.00	OPERATING ROOM	50.00	0	4,379	0		1.00
	TOTALS		0	4,379			
500.00	Grand Total: Decreases		131,290	78,381			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151312

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/24/2012 1:07 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	954,570	0	0	0	0	1.00
2.00	Land Improvements	1,845,690	0	0	0	0	2.00
3.00	Buildings and Fixtures	32,031,505	0	0	0	2,088	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	7,678,426	0	0	0	286,935	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	42,510,191	0	0	0	289,023	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	42,510,191	0	0	0	289,023	10.00
SUMMARY OF CAPITAL							
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	CAP REL COSTS-BLDG & FIXT	81,579	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-HOSP	1,969,545	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT-TLMAB	462,345	0	0	0	0	1.02
3.00	Total (sum of lines 1-2)	2,513,469	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	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-HOSP	0	0	0	0.000000	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT-TLMAB	0	0	0	0.000000	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151312

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/24/2012 1:07 pm

		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	954,570	0					1.00
2.00	Land Improvements	1,845,690	0					2.00
3.00	Buildings and Fixtures	32,029,417	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	7,391,491	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	42,221,168	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	42,221,168	0					10.00
SUMMARY OF CAPITAL								
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)					
		14.00	15.00					
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2								
1.00	CAP REL COSTS-BLDG & FIXT	0	81,579					1.00
1.01	CAP REL COSTS-BLDG & FIXT-HOSP	0	1,969,545					1.01
1.02	CAP REL COSTS-BLDG & FIXT-TLMAB	0	462,345					1.02
3.00	Total (sum of lines 1-2)	0	2,513,469					3.00
ALLOCATION OF OTHER CAPITAL								
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease		
		6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	81,579	0	1.00	
1.01	CAP REL COSTS-BLDG & FIXT-HOSP	0	0	0	2,018,309	0	1.01	
1.02	CAP REL COSTS-BLDG & FIXT-TLMAB	0	0	0	462,345	0	1.02	
3.00	Total (sum of lines 1-2)	0	0	0	2,562,233	0	3.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151312

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/24/2012 1:07 pm

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	81,579	1.00
1.01	CAP REL COSTS-BLDG & FIXT-HOSP	-33,368	0	0	0	1,984,941	1.01
1.02	CAP REL COSTS-BLDG & FIXT-TLMAB	-8,411	0	0	0	453,934	1.02
3.00	Total (sum of lines 1-2)	-41,779	0	0	0	2,520,454	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151312

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

Worksheet A-8

Date/Time Prepared:
1/24/2012 1:07 pm

	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			0	CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00			0	*** Cost Center Deleted ***	2.00	2.00
3.00		0			0.00	3.00
4.00		0			0.00	4.00
5.00		0			0.00	5.00
6.00		0			0.00	6.00
7.00		0			0.00	7.00
8.00		0			0.00	8.00
9.00		0			0.00	9.00
10.00	A-8-2	-953,785				10.00
11.00		0			0.00	11.00
12.00	A-8-1	0				12.00
13.00		0			0.00	13.00
14.00		0			0.00	14.00
15.00		0			0.00	15.00
16.00		0			0.00	16.00
17.00		0			0.00	17.00
18.00		0			0.00	18.00
19.00		0			0.00	19.00
20.00		0			0.00	20.00
21.00		0			0.00	21.00
22.00		0			0.00	22.00
23.00	A-8-3	0		*** Cost Center Deleted ***	65.00	23.00
24.00	A-8-3	0		PHYSICAL THERAPY	66.00	24.00
25.00		0		*** Cost Center Deleted ***	114.00	25.00
26.00		0		CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00		0		*** Cost Center Deleted ***	2.00	27.00
28.00		0		*** Cost Center Deleted ***	19.00	28.00
29.00		0			0.00	29.00
30.00	A-8-3	0		OCCUPATIONAL THERAPY	67.00	30.00
31.00	A-8-3	0		SPEECH PATHOLOGY	68.00	31.00
32.00		0			0.00	32.00
33.00	A	-7,798		ADMINISTRATIVE & GENERAL	5.00	33.00
33.01	B	-326		ADMINISTRATIVE & GENERAL	5.00	33.01
33.02	B	-10,533		DIETARY	10.00	33.02
33.03	A	-38,203		ADMINISTRATIVE & GENERAL	5.00	33.03
33.04	A	-681		ADMINISTRATIVE & GENERAL	5.00	33.04
33.05	A	-64,741		OPERATING ROOM	50.00	33.05
33.06	B	-33,368		CAP REL COSTS-BLDG & FIXT-HOSP	1.01	33.06
33.07	B	-8,411		CAP REL COSTS-BLDG & FIXT-TLMAB	1.02	33.07
33.08	B	-480		ADMINISTRATIVE & GENERAL	5.00	33.08
33.09	B	-700		ADMINISTRATIVE & GENERAL	5.00	33.09
33.10	B	-2,400		ADMINISTRATIVE & GENERAL	5.00	33.10
33.11	B	-652		ADMINISTRATIVE & GENERAL	5.00	33.11
33.12	B	-774		ADMINISTRATIVE & GENERAL	5.00	33.12
33.13	B	44		ADMINISTRATIVE & GENERAL	5.00	33.13
33.14	A	-104,235		DIETARY	10.00	33.14
33.15	B	-32		DIETARY	10.00	33.15
33.16	B	-47,174		CAFETERIA	11.00	33.16
33.17	B	-42,003		CENTRAL SERVICES & SUPPLY	14.00	33.17
33.18	B	-30,278		PHARMACY	15.00	33.18
33.19	B	-60		MEDICAL RECORDS & LIBRARY	16.00	33.19

ADJUSTMENTS TO EXPENSES

Provider CCN: 151312

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

Worksheet A-8

Date/Time Prepared:
1/24/2012 1:07 pm

				Expense Classification on worksheet A To/From Which the Amount is to be Adjusted		
		Basis/Code (2)	Amount	Cost Center	Line #	
		1.00	2.00	3.00	4.00	
33.20	SALE OF XRAY FILM	B	-719	RADIOLOGY-DIAGNOSTIC	54.00	33.20
33.21	ENPC EMERGENCY NURSE	B	-1,690	EMERGENCY	91.00	33.21
33.22	COMMUNITY HEALTH PROGRAM	B	-180	ADMINISTRATIVE & GENERAL	5.00	33.22
33.23	LOSS ON ABANDONMENT	A	48,764	CAP REL COSTS-BLDG & FIXT-HOSP	1.01	33.23
33.24	ORGANIZATION DONATIONS	A	-10,000	ADMINISTRATIVE & GENERAL	5.00	33.24
33.25	WIC PROGRAM BENEFITS	A	-20,362	EMPLOYEE BENEFITS	4.00	33.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-1,330,777			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151312

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

Worksheet A-8

Date/Time Prepared:
1/24/2012 1:07 pm

	Wkst. A-7 Ref.		
	5.00		
1.00	Investment income - buildings and fixtures (chapter 2)	0	1.00
2.00	Investment income - movable equipment (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - buildings and fixtures	0	26.00
27.00	Depreciation - movable equipment	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	PHYSICIAN RECRUITMENT	0	33.00
33.01	MISCELLANEOUS REVENUE	0	33.01
33.02	MISCELLANEOUS REVENUE	0	33.02
33.03	ADVERTISING A&G	0	33.03
33.04	IHHA & AHA LOBBYING	0	33.04
33.05	CRNA EXPENSE	0	33.05
33.06	INTEREST INCOME	11	33.06
33.07	INTEREST INCOME	11	33.07
33.08	SAFE SITTER	0	33.08
33.09	DOCTORS APPLICATION FEE	0	33.09
33.10	O'CONNOR RENTAL	0	33.10
33.11	GROUP PURCHASE REBATE	0	33.11
33.12	CPR	0	33.12
33.13	CASH SHORT OR LONG	0	33.13
33.14	WIC PROGRAM	0	33.14
33.15	DIETARY MISC REVENUE	0	33.15
33.16	CAFETERIA	0	33.16
33.17	MATERIALS MANAGEMENT	0	33.17
33.18	SALE OF PHARMACY	0	33.18
33.19	SALE OF MEDICAL RECORDS	0	33.19
33.20	SALE OF XRAY FILM	0	33.20
33.21	ENPC EMERGENCY NURSE	0	33.21
33.22	COMMUNITY HEALTH PROGRAM	0	33.22
33.23	LOSS ON ABANDONMENT	9	33.23
33.24	ORGANIZATION DONATIONS	0	33.24
33.25	WIC PROGRAM BENEFITS	0	33.25
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: 151312

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

Worksheet A-8-2

Date/Time Prepared:
1/24/2012 1:07 pm

	wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	30.00	PHYSICIAN FEES-OB	137,214	137,214	1.00
2.00	50.00	PHYSICIAN FEES-OR	69,500	69,500	2.00
3.00	50.00	PHYSICIAN FEES-ANESTHESIA	224,600	224,600	3.00
4.00	54.00	PHYSICIAN FEES-RADIOLOGY	350,000	350,000	4.00
5.00	60.00	PHYSICIAN FEES-LAB	24,000	11,760	5.00
6.00	57.00	PHYSICIAN FEES-CT SCAN	120,600	120,600	6.00
7.00	76.01	PHYSICIAN FEES-ONCOLOGY	37,500	37,500	7.00
8.00	76.02	PHYSICIAN FEES-CARDIO	2,611	2,611	8.00
9.00	91.00	PHYSICIAN FEES-EMERGENCY	348,000	0	9.00
10.00	0.00		0	0	10.00
200.00		TOTAL (lines 1.00 through 199.00)	1,314,025	953,785	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151312

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

Worksheet A-8-2

Date/Time Prepared:
1/24/2012 1:07 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	12,240	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	348,000	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	360,240		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151312

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

Worksheet A-8-2

Date/Time Prepared:
1/24/2012 1:07 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151312

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

Worksheet A-8-2
Date/Time Prepared:
1/24/2012 1:07 pm

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	137,214	1.00
2.00	0	69,500	2.00
3.00	0	224,600	3.00
4.00	0	350,000	4.00
5.00	0	11,760	5.00
6.00	0	120,600	6.00
7.00	0	37,500	7.00
8.00	0	2,611	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	953,785	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/24/2012 1:07 pm
		Physical Therapy	Cost

		1.00	
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PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						780	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						186	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						4.85	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	0.00	569.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	64.41	52.19	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	32.21	32.21	26.10			11.00	
12.00	Number of travel hours (provider site)	0	0	0			12.00	
12.01	Number of travel hours (offsite)	0	0	0			12.01	
13.00	Number of miles driven (provider site)	0	0	0			13.00	
13.01	Number of miles driven (offsite)	0	0	0			13.01	

							1.00	
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Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						0	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						29,696	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						29,696	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						29,696	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						52.19	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						40,708	22.00
23.00	Total salary equivalency (see instructions)						40,708	23.00

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)						25,124	24.00
25.00	Assistants (line 4 times column 3, line 11)						4,855	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						29,979	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						4,685	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						34,664	28.00
Optional Travel Allowance and Optional Travel Expense								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						4,855	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00

Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/24/2012 1:07 pm
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	Physical Therapy	Cost
		1.00

46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	

PART V - OVERTIME COMPUTATION

47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00

CALCULATION OF LIMIT

50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00

DETERMINATION OF OVERTIME ALLOWANCE

52.00	Adjusted hourly salary equivalency amount (see instructions)	64.41	52.19	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

1.00

Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57.00	Salary equivalency amount (from line 23)					40,708	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)					4,855	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					45,563	63.00
64.00	Total cost of outside supplier services (from your records)					24,281	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00

LINE 33 CALCULATION

100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					29,979	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					4,685	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					34,664	100.02

LINE 34 CALCULATION

101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					4,685	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					4,685	101.02

LINE 35 CALCULATION

102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	
		BLDG & FIXT	BLDG & FIXT-HOSP	BLDG & FIXT-TLMAB		
	0	1.00	1.01	1.02	4.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	81,579	81,579			1.00
1.01	CAP REL COSTS-BLDG & FIXT-HOSP	1,984,941	0	1,984,941		1.01
1.02	CAP REL COSTS-BLDG & FIXT-TLMAB	453,934	0	0	453,934	1.02
4.00	EMPLOYEE BENEFITS	1,043,561	0	0	0	1,043,561
5.00	ADMINISTRATIVE & GENERAL	1,444,220	9,308	128,039	94,732	143,956
7.00	OPERATION OF PLANT	85,726	0	0	0	18,224
7.01	OPERATION OF PLANT-HOSPITAL	283,020	2,630	97,557	0	0
7.02	OPERATION OF PLANT-TLMAB	79,940	723	0	11,690	0
8.00	LAUNDRY & LINEN SERVICE	55,155	0	0	0	0
9.00	HOUSEKEEPING	183,851	1,909	67,796	1,304	29,382
10.00	DIETARY	140,098	1,717	0	27,781	33,380
11.00	CAFETERIA	90,193	1,681	0	27,199	17,390
13.00	NURSING ADMINISTRATION	313,323	124	0	2,003	59,540
14.00	CENTRAL SERVICES & SUPPLY	21,735	1,010	37,475	0	7,889
15.00	PHARMACY	972,758	1,254	46,497	0	14,549
16.00	MEDICAL RECORDS & LIBRARY	110,788	1,134	0	18,350	19,870
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	699,915	12,110	449,217	0	125,831
31.00	INTENSIVE CARE UNIT	86,364	1,451	53,810	0	13,994
43.00	NURSERY	55,080	292	10,837	0	9,229
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	582,292	7,789	288,856	0	71,178
52.00	DELIVERY ROOM & LABOR ROOM	62,790	556	20,606	0	10,521
54.00	RADIOLOGY-DIAGNOSTIC	424,268	4,926	182,703	0	43,474
55.00	RADIOLOGY-THERAPEUTIC	106,498	296	10,970	0	5,751
56.00	RADIOISOTOPE	230,854	260	9,636	0	16,632
57.00	CT SCAN	213,322	356	13,186	0	16,611
58.00	MAGNETIC RESONANCE IMAGING (MRI)	271,708	0	0	0	11,923
60.00	LABORATORY	746,294	2,035	75,457	0	61,768
66.00	PHYSICAL THERAPY	159,223	1,860	68,998	0	31,046
67.00	OCCUPATIONAL THERAPY	39,926	0	0	0	8,423
68.00	SPEECH PATHOLOGY	40,045	0	0	0	7,887
69.00	ELECTROCARDIOLOGY	35,055	304	11,264	0	2,561
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	IMPL. DEV. CHARGED TO PATIENTS	4,379	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00		0	0	0	0	0
76.01	ONCOLOGY	64,163	1,348	49,993	0	10,877
76.02	CARDIOPULMONARY	202,758	1,144	42,440	0	35,983
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	51,938	0	0	0	9,294
91.00	EMERGENCY	883,447	5,834	216,361	0	93,288
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					
92.01	OBSERVATION BEDS (DISTINCT PART)	74,945	2,784	103,243	0	15,313
OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	72,790	1,235	0	19,980	8,714
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
101.00	HOME HEALTH AGENCY	246,324	677	0	10,945	41,926
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	12,699,200	66,747	1,984,941	213,984	996,404
NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	2,856	0	46,201	0
192.01	PHYSICIANS' PRIVATE OFFICES	271,508	1,264	0	20,446	42,832
192.02	PHYSICIANS' PRIVATE OFFICES	1,152	10,676	0	172,721	0
192.03	PHYSICIANS' PRIVATE OFFICES	71,797	0	0	0	4,325
194.00	OCCUPATIONAL MEDICINE	4,863	0	0	0	0
194.01	VENDING ROOM	0	36	0	582	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	TOTAL (sum lines 118-201)	13,048,520	81,579	1,984,941	453,934	1,043,561

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151312

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

Worksheet B
Part I
Date/Time Prepared:
1/24/2012 1:07 pm

Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-HOSPITAL	OPERATION OF PLANT-TLMAB	
		4A	5.00	7.00	7.01	7.02	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BLDG & FIXT-HOSP						1.01
1.02	CAP REL COSTS-BLDG & FIXT-TLMAB						1.02
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	1,820,255	1,820,255				5.00
7.00	OPERATION OF PLANT	103,950	16,852	120,802			7.00
7.01	OPERATION OF PLANT-HOSPITAL	383,207	62,123	4,397	449,727		7.01
7.02	OPERATION OF PLANT-TLMAB	92,353	14,972	1,208	0	108,533	7.02
8.00	LAUNDRY & LINEN SERVICE	55,155	8,941	0	0	0	8.00
9.00	HOUSEKEEPING	284,242	46,080	3,190	17,330	407	9.00
10.00	DIETARY	202,976	32,905	2,870	0	8,677	10.00
11.00	CAFETERIA	136,463	22,123	2,810	0	8,495	11.00
13.00	NURSING ADMINISTRATION	374,990	60,791	207	0	625	13.00
14.00	CENTRAL SERVICES & SUPPLY	68,109	11,041	1,689	9,579	0	14.00
15.00	PHARMACY	1,035,058	167,797	2,096	11,886	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	150,142	24,340	1,896	0	5,731	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,287,073	208,650	20,248	114,832	0	30.00
31.00	INTENSIVE CARE UNIT	155,619	25,228	2,425	13,755	0	31.00
43.00	NURSERY	75,438	12,230	488	2,770	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	950,115	154,027	13,019	73,838	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	94,473	15,315	929	5,267	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	655,371	106,245	8,234	46,703	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	123,515	20,024	494	2,804	0	55.00
56.00	RADIOISOTOPE	257,382	41,725	434	2,463	0	56.00
57.00	CT SCAN	243,475	39,471	594	3,371	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	283,631	45,981	0	0	0	58.00
60.00	LABORATORY	885,554	143,561	3,401	19,288	0	60.00
66.00	PHYSICAL THERAPY	261,127	42,332	3,110	17,637	0	66.00
67.00	OCCUPATIONAL THERAPY	48,349	7,838	0	0	0	67.00
68.00	SPEECH PATHOLOGY	47,932	7,770	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	49,184	7,973	508	2,879	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	4,379	710	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00		0	0	0	0	0	76.00
76.01	ONCOLOGY	126,381	20,488	2,253	12,779	0	76.01
76.02	CARDIOPULMONARY	282,325	45,769	1,913	10,848	0	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	61,232	9,927	0	0	0	90.00
91.00	EMERGENCY	1,198,930	194,363	9,751	55,307	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	196,285	31,821	4,653	26,391	0	92.01
OTHER REIMBURSABLE COST CENTERS							
96.00	DURABLE MEDICAL EQUIP-RENTED	102,719	16,652	2,064	0	6,240	96.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	HOME HEALTH AGENCY	299,872	48,613	1,131	0	3,418	101.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	12,397,261	1,714,678	96,012	449,727	33,593	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	49,057	7,953	4,773	0	14,429	192.00
192.01	PHYSICIANS' PRIVATE OFFICES	336,050	54,478	2,112	0	6,386	192.01
192.02	PHYSICIANS' PRIVATE OFFICES	184,549	29,918	17,845	0	53,943	192.02
192.03	PHYSICIANS' PRIVATE OFFICES	76,122	12,340	0	0	0	192.03
194.00	OCCUPATIONAL MEDICINE	4,863	788	0	0	0	194.00
194.01	VENDING ROOM	618	100	60	0	182	194.01
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	13,048,520	1,820,255	120,802	449,727	108,533	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151312

Period:
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To 06/30/2011

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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BLDG & FIXT-HOSP						1.01
1.02	CAP REL COSTS-BLDG & FIXT-TLMAB						1.02
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT-HOSPITAL						7.01
7.02	OPERATION OF PLANT-TLMAB						7.02
8.00	LAUNDRY & LINEN SERVICE	64,096					8.00
9.00	HOUSEKEEPING	490	351,739				9.00
10.00	DIETARY	451	23,948	271,827			10.00
11.00	CAFETERIA	0	0	0	169,891		11.00
13.00	NURSING ADMINISTRATION	0	0	0	9,063	445,676	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	15,217	0	2,067	0	14.00
15.00	PHARMACY	0	0	0	3,279	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	5,492	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	12,778	90,803	266,082	32,996	171,499	30.00
31.00	INTENSIVE CARE UNIT	6,416	26,443	5,745	2,506	13,013	31.00
43.00	NURSERY	1,075	0	0	1,973	10,239	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	13,501	0	0	11,767	61,159	50.00
52.00	DELIVERY ROOM & LABOR ROOM	1,229	0	0	2,245	11,669	52.00
54.00	RADIOLOGY-DIAGNOSTIC	4,667	15,716	0	1,044	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	1,096	0	55.00
56.00	RADIOISOTOPE	0	0	0	2,391	0	56.00
57.00	CT SCAN	0	0	0	2,809	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,253	0	58.00
60.00	LABORATORY	0	14,968	0	25,226	0	60.00
66.00	PHYSICAL THERAPY	1,080	11,226	0	6,171	5,373	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	1,034	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	908	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	1,149	5,970	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00		0	0	0	0	0	76.00
76.01	ONCOLOGY	466	0	0	2,328	12,076	76.01
76.02	CARDIOPULMONARY	624	8,232	0	8,792	45,709	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	699	14,718	0	3,748	0	90.00
91.00	EMERGENCY	14,169	37,419	0	18,826	97,850	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	5,965	0	0	3,654	0	92.01
OTHER REIMBURSABLE COST CENTERS							
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	2,140	0	96.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	HOME HEALTH AGENCY	0	5,239	0	10,849	11,119	101.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	63,610	263,929	271,827	164,806	445,676	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	0	29,187	0	1,055	0	192.00
192.01	PHYSICIANS' PRIVATE OFFICES	486	5,488	0	4,030	0	192.01
192.02	PHYSICIANS' PRIVATE OFFICES	0	53,135	0	0	0	192.02
192.03	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.03
194.00	OCCUPATIONAL MEDICINE	0	0	0	0	0	194.00
194.01	VENDING ROOM	0	0	0	0	0	194.01
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)	64,096	351,739	271,827	169,891	445,676	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BLDG & FIXT-HOSP						1.01
1.02	CAP REL COSTS-BLDG & FIXT-TLMAB						1.02
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT-HOSPITAL						7.01
7.02	OPERATION OF PLANT-TLMAB						7.02
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY	107,702					14.00
15.00	PHARMACY	846	1,220,962				15.00
16.00	MEDICAL RECORDS & LIBRARY	182	0	187,783			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	6,546	0	32,612	2,244,119	0	30.00
31.00	INTENSIVE CARE UNIT	786	0	365	252,301	0	31.00
43.00	NURSERY	742	0	1,702	106,657	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	25,395	0	16,135	1,318,956	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	846	0	1,938	133,911	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	493	0	66,591	905,064	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	760	0	0	148,693	0	55.00
56.00	RADIOISOTOPE	179	0	0	304,574	0	56.00
57.00	CT SCAN	976	0	0	290,696	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	22	0	0	330,887	0	58.00
60.00	LABORATORY	44,442	0	12,182	1,148,622	0	60.00
66.00	PHYSICAL THERAPY	961	0	1,137	350,154	0	66.00
67.00	OCCUPATIONAL THERAPY	47	0	0	57,268	0	67.00
68.00	SPEECH PATHOLOGY	382	0	0	56,992	0	68.00
69.00	ELECTROCARDIOLOGY	475	0	0	68,138	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,089	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,220,962	0	1,220,962	0	73.00
76.00		0	0	0	0	0	76.00
76.01	ONCOLOGY	788	0	0	177,559	0	76.01
76.02	CARDIOPULMONARY	2,956	0	1,697	408,865	0	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	649	0	2,168	93,141	0	90.00
91.00	EMERGENCY	10,227	0	51,256	1,688,098	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	493	0	0	269,262	0	92.01
OTHER REIMBURSABLE COST CENTERS							
96.00	DURABLE MEDICAL EQUIP-RENTED	3,703	0	0	133,518	0	96.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	HOME HEALTH AGENCY	658	0	0	380,899	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	103,554	1,220,962	187,783	12,094,425	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	106,454	0	192.00
192.01	PHYSICIANS' PRIVATE OFFICES	4,140	0	0	413,170	0	192.01
192.02	PHYSICIANS' PRIVATE OFFICES	0	0	0	339,390	0	192.02
192.03	PHYSICIANS' PRIVATE OFFICES	7	0	0	88,469	0	192.03
194.00	OCCUPATIONAL MEDICINE	1	0	0	5,652	0	194.00
194.01	VENDING ROOM	0	0	0	960	0	194.01
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	107,702	1,220,962	187,783	13,048,520	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151312

Period:
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT		1.00
1.01	CAP REL COSTS-BLDG & FIXT-HOSP		1.01
1.02	CAP REL COSTS-BLDG & FIXT-TLMAB		1.02
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
7.00	OPERATION OF PLANT		7.00
7.01	OPERATION OF PLANT-HOSPITAL		7.01
7.02	OPERATION OF PLANT-TLMAB		7.02
8.00	LAUNDRY & LINEN SERVICE		8.00
9.00	HOUSEKEEPING		9.00
10.00	DIETARY		10.00
11.00	CAFETERIA		11.00
13.00	NURSING ADMINISTRATION		13.00
14.00	CENTRAL SERVICES & SUPPLY		14.00
15.00	PHARMACY		15.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,244,119	30.00
31.00	INTENSIVE CARE UNIT	252,301	31.00
43.00	NURSERY	106,657	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	1,318,956	50.00
52.00	DELIVERY ROOM & LABOR ROOM	133,911	52.00
54.00	RADIOLOGY-DIAGNOSTIC	905,064	54.00
55.00	RADIOLOGY-THERAPEUTIC	148,693	55.00
56.00	RADIOISOTOPE	304,574	56.00
57.00	CT SCAN	290,696	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	330,887	58.00
60.00	LABORATORY	1,148,622	60.00
66.00	PHYSICAL THERAPY	350,154	66.00
67.00	OCCUPATIONAL THERAPY	57,268	67.00
68.00	SPEECH PATHOLOGY	56,992	68.00
69.00	ELECTROCARDIOLOGY	68,138	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	5,089	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,220,962	73.00
76.00		0	76.00
76.01	ONCOLOGY	177,559	76.01
76.02	CARDIOPULMONARY	408,865	76.02
OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	93,141	90.00
91.00	EMERGENCY	1,688,098	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	269,262	92.01
OTHER REIMBURSABLE COST CENTERS			
96.00	DURABLE MEDICAL EQUIP-RENTED	133,518	96.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	98.00
101.00	HOME HEALTH AGENCY	380,899	101.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	12,094,425	118.00
NONREIMBURSABLE COST CENTERS			
192.00	PHYSICIANS' PRIVATE OFFICES	106,454	192.00
192.01	PHYSICIANS' PRIVATE OFFICES	413,170	192.01
192.02	PHYSICIANS' PRIVATE OFFICES	339,390	192.02
192.03	PHYSICIANS' PRIVATE OFFICES	88,469	192.03
194.00	OCCUPATIONAL MEDICINE	5,652	194.00
194.01	VENDING ROOM	960	194.01
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	13,048,520	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151312

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

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		BLDG & FIXT	BLDG & FIXT-HOSP	BLDG & FIXT-TLMAB		
	0	1.00	1.01	1.02	2A	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
1.01	CAP REL COSTS-BLDG & FIXT-HOSP					1.01
1.02	CAP REL COSTS-BLDG & FIXT-TLMAB					1.02
4.00	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	0	9,308	128,039	94,732	232,079 5.00
7.00	OPERATION OF PLANT	0	0	0	0	7.00
7.01	OPERATION OF PLANT-HOSPITAL	0	2,630	97,557	0	100,187 7.01
7.02	OPERATION OF PLANT-TLMAB	0	723	0	11,690	12,413 7.02
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	HOUSEKEEPING	0	1,909	67,796	1,304	71,009 9.00
10.00	DIETARY	0	1,717	0	27,781	29,498 10.00
11.00	CAFETERIA	0	1,681	0	27,199	28,880 11.00
13.00	NURSING ADMINISTRATION	0	124	0	2,003	2,127 13.00
14.00	CENTRAL SERVICES & SUPPLY	0	1,010	37,475	0	38,485 14.00
15.00	PHARMACY	0	1,254	46,497	0	47,751 15.00
16.00	MEDICAL RECORDS & LIBRARY	0	1,134	0	18,350	19,484 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	12,110	449,217	0	461,327 30.00
31.00	INTENSIVE CARE UNIT	0	1,451	53,810	0	55,261 31.00
43.00	NURSERY	0	292	10,837	0	11,129 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	7,789	288,856	0	296,645 50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	556	20,606	0	21,162 52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	4,926	182,703	0	187,629 54.00
55.00	RADIOLOGY-THERAPEUTIC	0	296	10,970	0	11,266 55.00
56.00	RADIOISOTOPE	0	260	9,636	0	9,896 56.00
57.00	CT SCAN	0	356	13,186	0	13,542 57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	LABORATORY	0	2,035	75,457	0	77,492 60.00
66.00	PHYSICAL THERAPY	0	1,860	68,998	0	70,858 66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	304	11,264	0	11,568 69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00		0	0	0	0	76.00
76.01	ONCOLOGY	0	1,348	49,993	0	51,341 76.01
76.02	CARDIOPULMONARY	0	1,144	42,440	0	43,584 76.02
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	90.00
91.00	EMERGENCY	0	5,834	216,361	0	222,195 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	0	2,784	103,243	0	106,027 92.01
OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	1,235	0	19,980	21,215 96.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
101.00	HOME HEALTH AGENCY	0	677	0	10,945	11,622 101.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	66,747	1,984,941	213,984	2,265,672 118.00
NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	2,856	0	46,201	49,057 192.00
192.01	PHYSICIANS' PRIVATE OFFICES	0	1,264	0	20,446	21,710 192.01
192.02	PHYSICIANS' PRIVATE OFFICES	0	10,676	0	172,721	183,397 192.02
192.03	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.03
194.00	OCCUPATIONAL MEDICINE	0	0	0	0	194.00
194.01	VENDING ROOM	0	36	0	582	618 194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	81,579	1,984,941	453,934	2,520,454 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151312		Period: From 01/01/2011 To 06/30/2011		Worksheet B Part II Date/Time Prepared: 1/24/2012 1:07 pm	
Cost Center Description	EMPLOYEE BENEFITS 4.00	ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	OPERATION OF PLANT-HOSPITAL 7.01	OPERATION OF PLANT-TLMAB 7.02		
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BLDG & FIXT-HOSP						1.01
1.02	CAP REL COSTS-BLDG & FIXT-TLMAB						1.02
4.00	EMPLOYEE BENEFITS	0					4.00
5.00	ADMINISTRATIVE & GENERAL	0	232,079				5.00
7.00	OPERATION OF PLANT	0	2,149	2,149			7.00
7.01	OPERATION OF PLANT-HOSPITAL	0	7,921	78	108,186		7.01
7.02	OPERATION OF PLANT-TLMAB	0	1,909	21	0	14,343	7.02
8.00	LAUNDRY & LINEN SERVICE	0	1,140	0	0	0	8.00
9.00	HOUSEKEEPING	0	5,875	57	4,169	54	9.00
10.00	DIETARY	0	4,195	51	0	1,147	10.00
11.00	CAFETERIA	0	2,821	50	0	1,123	11.00
13.00	NURSING ADMINISTRATION	0	7,751	4	0	83	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	1,408	30	2,304	0	14.00
15.00	PHARMACY	0	21,394	37	2,859	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	3,103	34	0	757	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	26,602	360	27,622	0	30.00
31.00	INTENSIVE CARE UNIT	0	3,216	43	3,309	0	31.00
43.00	NURSERY	0	1,559	9	666	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	19,638	232	17,762	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	1,953	17	1,267	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	13,546	146	11,235	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	2,553	9	675	0	55.00
56.00	RADIOISOTOPE	0	5,320	8	593	0	56.00
57.00	CT SCAN	0	5,032	11	811	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	5,862	0	0	0	58.00
60.00	LABORATORY	0	18,304	60	4,640	0	60.00
66.00	PHYSICAL THERAPY	0	5,397	55	4,243	0	66.00
67.00	OCCUPATIONAL THERAPY	0	999	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	991	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	1,017	9	693	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	91	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00		0	0	0	0	0	76.00
76.01	ONCOLOGY	0	2,612	40	3,074	0	76.01
76.02	CARDIOPULMONARY	0	5,835	34	2,610	0	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	1,266	0	0	0	90.00
91.00	EMERGENCY	0	24,781	173	13,305	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	0	4,057	83	6,349	0	92.01
OTHER REIMBURSABLE COST CENTERS							
96.00	DURABLE MEDICAL EQUIP-RENTED	0	2,123	37	0	825	96.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	HOME HEALTH AGENCY	0	6,198	20	0	452	101.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	218,618	1,708	108,186	4,441	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	0	1,014	85	0	1,907	192.00
192.01	PHYSICIANS' PRIVATE OFFICES	0	6,946	38	0	844	192.01
192.02	PHYSICIANS' PRIVATE OFFICES	0	3,814	317	0	7,127	192.02
192.03	PHYSICIANS' PRIVATE OFFICES	0	1,573	0	0	0	192.03
194.00	OCCUPATIONAL MEDICINE	0	101	0	0	0	194.00
194.01	VENDING ROOM	0	13	1	0	24	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	232,079	2,149	108,186	14,343	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet B Part II Date/Time Prepared: 1/24/2012 1:07 pm
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BLDG & FIXT-HOSP						1.01
1.02	CAP REL COSTS-BLDG & FIXT-TLMAB						1.02
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT-HOSPITAL						7.01
7.02	OPERATION OF PLANT-TLMAB						7.02
8.00	LAUNDRY & LINEN SERVICE	1,140					8.00
9.00	HOUSEKEEPING		81,173				9.00
10.00	DIETARY		5,527	40,426			10.00
11.00	CAFETERIA				32,874		11.00
13.00	NURSING ADMINISTRATION				1,754	11,719	13.00
14.00	CENTRAL SERVICES & SUPPLY		3,512		400		14.00
15.00	PHARMACY				634		15.00
16.00	MEDICAL RECORDS & LIBRARY				1,063		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	227	20,954	39,572	6,386	4,510	30.00
31.00	INTENSIVE CARE UNIT	114	6,102	854	485	342	31.00
43.00	NURSERY	19	0	0	382	269	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	240	0	0	2,277	1,608	50.00
52.00	DELIVERY ROOM & LABOR ROOM	22	0	0	434	307	52.00
54.00	RADIOLOGY-DIAGNOSTIC	83	3,627	0	202	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	212	0	55.00
56.00	RADIOISOTOPE	0	0	0	463	0	56.00
57.00	CT SCAN	0	0	0	543	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	242	0	58.00
60.00	LABORATORY	0	3,454	0	4,881	0	60.00
66.00	PHYSICAL THERAPY	19	2,591	0	1,194	141	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	200	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	176	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	222	157	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00		0	0	0	0	0	76.00
76.01	ONCOLOGY	8	0	0	451	318	76.01
76.02	CARDIOPULMONARY	11	1,900	0	1,701	1,202	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	12	3,397	0	725	0	90.00
91.00	EMERGENCY	253	8,635	0	3,643	2,573	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	106	0	0	707	0	92.01
OTHER REIMBURSABLE COST CENTERS							
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	414	0	96.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	HOME HEALTH AGENCY	0	1,209	0	2,099	292	101.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,131	60,908	40,426	31,890	11,719	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	0	6,736	0	204	0	192.00
192.01	PHYSICIANS' PRIVATE OFFICES	9	1,267	0	780	0	192.01
192.02	PHYSICIANS' PRIVATE OFFICES	0	12,262	0	0	0	192.02
192.03	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.03
194.00	OCCUPATIONAL MEDICINE	0	0	0	0	0	194.00
194.01	VENDING ROOM	0	0	0	0	0	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,140	81,173	40,426	32,874	11,719	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151312

Period:
From 01/01/2011
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Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BLDG & FIXT-HOSP						1.01
1.02	CAP REL COSTS-BLDG & FIXT-TLMAB						1.02
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT-HOSPITAL						7.01
7.02	OPERATION OF PLANT-TLMAB						7.02
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY	46,139					14.00
15.00	PHARMACY	362	73,037				15.00
16.00	MEDICAL RECORDS & LIBRARY	78	0	24,519			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,804	0	4,258	594,622	0	30.00
31.00	INTENSIVE CARE UNIT	337	0	48	70,111	0	31.00
43.00	NURSERY	318	0	222	14,573	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	10,879	0	2,107	351,388	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	363	0	253	25,778	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	211	0	8,694	225,373	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	326	0	0	15,041	0	55.00
56.00	RADIOISOTOPE	77	0	0	16,357	0	56.00
57.00	CT SCAN	418	0	0	20,357	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	9	0	0	6,113	0	58.00
60.00	LABORATORY	19,038	0	1,591	129,460	0	60.00
66.00	PHYSICAL THERAPY	412	0	148	85,058	0	66.00
67.00	OCCUPATIONAL THERAPY	20	0	0	1,219	0	67.00
68.00	SPEECH PATHOLOGY	164	0	0	1,331	0	68.00
69.00	ELECTROCARDIOLOGY	203	0	0	13,869	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	91	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	73,037	0	73,037	0	73.00
76.00		0	0	0	0	0	76.00
76.01	ONCOLOGY	338	0	0	58,182	0	76.01
76.02	CARDIOPULMONARY	1,266	0	222	58,365	0	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	278	0	283	5,961	0	90.00
91.00	EMERGENCY	4,381	0	6,693	286,632	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	211	0	0	117,540	0	92.01
OTHER REIMBURSABLE COST CENTERS							
96.00	DURABLE MEDICAL EQUIP-RENTED	1,586	0	0	26,200	0	96.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	HOME HEALTH AGENCY	282	0	0	22,174	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	44,361	73,037	24,519	2,218,832	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	59,003	0	192.00
192.01	PHYSICIANS' PRIVATE OFFICES	1,774	0	0	33,368	0	192.01
192.02	PHYSICIANS' PRIVATE OFFICES	0	0	0	206,917	0	192.02
192.03	PHYSICIANS' PRIVATE OFFICES	3	0	0	1,576	0	192.03
194.00	OCCUPATIONAL MEDICINE	1	0	0	102	0	194.00
194.01	VENDING ROOM	0	0	0	656	0	194.01
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	46,139	73,037	24,519	2,520,454	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151312

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

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Part II
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT		1.00
1.01	CAP REL COSTS-BLDG & FIXT-HOSP		1.01
1.02	CAP REL COSTS-BLDG & FIXT-TLMAB		1.02
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
7.00	OPERATION OF PLANT		7.00
7.01	OPERATION OF PLANT-HOSPITAL		7.01
7.02	OPERATION OF PLANT-TLMAB		7.02
8.00	LAUNDRY & LINEN SERVICE		8.00
9.00	HOUSEKEEPING		9.00
10.00	DIETARY		10.00
11.00	CAFETERIA		11.00
13.00	NURSING ADMINISTRATION		13.00
14.00	CENTRAL SERVICES & SUPPLY		14.00
15.00	PHARMACY		15.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	594,622	30.00
31.00	INTENSIVE CARE UNIT	70,111	31.00
43.00	NURSERY	14,573	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	351,388	50.00
52.00	DELIVERY ROOM & LABOR ROOM	25,778	52.00
54.00	RADIOLOGY-DIAGNOSTIC	225,373	54.00
55.00	RADIOLOGY-THERAPEUTIC	15,041	55.00
56.00	RADIOISOTOPE	16,357	56.00
57.00	CT SCAN	20,357	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	6,113	58.00
60.00	LABORATORY	129,460	60.00
66.00	PHYSICAL THERAPY	85,058	66.00
67.00	OCCUPATIONAL THERAPY	1,219	67.00
68.00	SPEECH PATHOLOGY	1,331	68.00
69.00	ELECTROCARDIOLOGY	13,869	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	91	72.00
73.00	DRUGS CHARGED TO PATIENTS	73,037	73.00
76.00		0	76.00
76.01	ONCOLOGY	58,182	76.01
76.02	CARDIOPULMONARY	58,365	76.02
OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	5,961	90.00
91.00	EMERGENCY	286,632	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	117,540	92.01
OTHER REIMBURSABLE COST CENTERS			
96.00	DURABLE MEDICAL EQUIP-RENTED	26,200	96.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	98.00
101.00	HOME HEALTH AGENCY	22,174	101.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,218,832	118.00
NONREIMBURSABLE COST CENTERS			
192.00	PHYSICIANS' PRIVATE OFFICES	59,003	192.00
192.01	PHYSICIANS' PRIVATE OFFICES	33,368	192.01
192.02	PHYSICIANS' PRIVATE OFFICES	206,917	192.02
192.03	PHYSICIANS' PRIVATE OFFICES	1,576	192.03
194.00	OCCUPATIONAL MEDICINE	102	194.00
194.01	VENDING ROOM	656	194.01
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	2,520,454	202.00

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-HOSP (SQUARE FEET)	BLDG & FIXT-TLMAB (SQUARE FEET)			
	1.00	1.01	1.02			
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT	113,352					1.00
1.01 CAP REL COSTS-BLDG & FIXT-HOSP	0	74,366				1.01
1.02 CAP REL COSTS-BLDG & FIXT-TLMAB	0	0	38,986			1.02
4.00 EMPLOYEE BENEFITS	0	0	0	4,908,793		4.00
5.00 ADMINISTRATIVE & GENERAL	12,933	4,797	8,136	677,157	-1,820,255	5.00
7.00 OPERATION OF PLANT	0	0	0	85,726	0	7.00
7.01 OPERATION OF PLANT-HOSPITAL	3,655	3,655	0	0	0	7.01
7.02 OPERATION OF PLANT-TLMAB	1,004	0	1,004	0	0	7.02
8.00 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00 HOUSEKEEPING	2,652	2,540	112	138,212	0	9.00
10.00 DIETARY	2,386	0	2,386	157,015	0	10.00
11.00 CAFETERIA	2,336	0	2,336	81,802	0	11.00
13.00 NURSING ADMINISTRATION	172	0	172	280,071	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	1,404	1,404	0	37,110	0	14.00
15.00 PHARMACY	1,742	1,742	0	68,438	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	1,576	0	1,576	93,464	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	16,830	16,830	0	591,895	0	30.00
31.00 INTENSIVE CARE UNIT	2,016	2,016	0	65,827	0	31.00
43.00 NURSERY	406	406	0	43,411	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	10,822	10,822	0	334,813	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	772	772	0	49,488	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	6,845	6,845	0	204,497	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	411	411	0	27,051	0	55.00
56.00 RADIOISOTOPE	361	361	0	78,235	0	56.00
57.00 CT SCAN	494	494	0	78,135	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	56,083	0	58.00
60.00 LABORATORY	2,827	2,827	0	290,552	0	60.00
66.00 PHYSICAL THERAPY	2,585	2,585	0	146,035	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	39,623	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	37,101	0	68.00
69.00 ELECTROCARDIOLOGY	422	422	0	12,045	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	0	0	0	0	0	76.00
76.01 ONCOLOGY	1,873	1,873	0	51,164	0	76.01
76.02 CARDIOPULMONARY	1,590	1,590	0	169,259	0	76.02
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	43,718	0	90.00
91.00 EMERGENCY	8,106	8,106	0	438,815	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01 OBSERVATION BEDS (DISTINCT PART)	3,868	3,868	0	72,031	0	92.01
OTHER REIMBURSABLE COST CENTERS						
96.00 DURABLE MEDICAL EQUIP-RENTED	1,716	0	1,716	40,988	0	96.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00 HOME HEALTH AGENCY	940	0	940	197,213	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	92,744	74,366	18,378	4,686,974	-1,820,255	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	3,968	0	3,968	0	0	192.00
192.01 PHYSICIANS' PRIVATE OFFICES	1,756	0	1,756	201,476	0	192.01
192.02 PHYSICIANS' PRIVATE OFFICES	14,834	0	14,834	0	0	192.02
192.03 PHYSICIANS' PRIVATE OFFICES	0	0	0	20,343	0	192.03
194.00 OCCUPATIONAL MEDICINE	0	0	0	0	0	194.00
194.01 VENDING ROOM	50	0	50	0	0	194.01
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)	81,579	1,984,941	453,934	1,043,561		202.00
203.00 Unit cost multiplier (wkst. B, Part I)	0.719696	26.691512	11.643513	0.212590		203.00
204.00 Cost to be allocated (per wkst. B, Part II)				0		204.00
205.00 Unit cost multiplier (wkst. B, Part II)				0.000000		205.00

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-HOSPITAL (SQUARE FEET)	OPERATION OF PLANT-TLMAB (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5.00	7.00	7.01	7.02	8.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BLDG & FIXT-HOSP						1.01
1.02	CAP REL COSTS-BLDG & FIXT-TLMAB						1.02
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	11,228,265					5.00
7.00	OPERATION OF PLANT	103,950	100,419				7.00
7.01	OPERATION OF PLANT-HOSPITAL	383,207	3,655	65,914			7.01
7.02	OPERATION OF PLANT-TLMAB	92,353	1,004	0	29,846		7.02
8.00	LAUNDRY & LINEN SERVICE	55,155	0	0	0	12,937	8.00
9.00	HOUSEKEEPING	284,242	2,652	2,540	112	99	9.00
10.00	DIETARY	202,976	2,386	0	2,386	91	10.00
11.00	CAFETERIA	136,463	2,336	0	2,336	0	11.00
13.00	NURSING ADMINISTRATION	374,990	172	0	172	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	68,109	1,404	1,404	0	0	14.00
15.00	PHARMACY	1,035,058	1,742	1,742	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	150,142	1,576	0	1,576	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,287,073	16,830	16,830	0	2,579	30.00
31.00	INTENSIVE CARE UNIT	155,619	2,016	2,016	0	1,295	31.00
43.00	NURSERY	75,438	406	406	0	217	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	950,115	10,822	10,822	0	2,725	50.00
52.00	DELIVERY ROOM & LABOR ROOM	94,473	772	772	0	248	52.00
54.00	RADIOLOGY-DIAGNOSTIC	655,371	6,845	6,845	0	942	54.00
55.00	RADIOLOGY-THERAPEUTIC	123,515	411	411	0	0	55.00
56.00	RADIOISOTOPE	257,382	361	361	0	0	56.00
57.00	CT SCAN	243,475	494	494	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	283,631	0	0	0	0	58.00
60.00	LABORATORY	885,554	2,827	2,827	0	0	60.00
66.00	PHYSICAL THERAPY	261,127	2,585	2,585	0	218	66.00
67.00	OCCUPATIONAL THERAPY	48,349	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	47,932	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	49,184	422	422	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	4,379	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00		0	0	0	0	0	76.00
76.01	ONCOLOGY	126,381	1,873	1,873	0	94	76.01
76.02	CARDIOPULMONARY	282,325	1,590	1,590	0	126	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	61,232	0	0	0	141	90.00
91.00	EMERGENCY	1,198,930	8,106	8,106	0	2,860	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	196,285	3,868	3,868	0	1,204	92.01
OTHER REIMBURSABLE COST CENTERS							
96.00	DURABLE MEDICAL EQUIP-RENTED	102,719	1,716	0	1,716	0	96.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	HOME HEALTH AGENCY	299,872	940	0	940	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	10,577,006	79,811	65,914	9,238	12,839	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	49,057	3,968	0	3,968	0	192.00
192.01	PHYSICIANS' PRIVATE OFFICES	336,050	1,756	0	1,756	98	192.01
192.02	PHYSICIANS' PRIVATE OFFICES	184,549	14,834	0	14,834	0	192.02
192.03	PHYSICIANS' PRIVATE OFFICES	76,122	0	0	0	0	192.03
194.00	OCCUPATIONAL MEDICINE	4,863	0	0	0	0	194.00
194.01	VENDING ROOM	618	50	0	50	0	194.01
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)	1,820,255	120,802	449,727	108,533	64,096	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.162114	1.202980	6.822936	3.636434	4.954472	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	232,079	2,149	108,186	14,343	1,140	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.020669	0.021400	1.641321	0.480567	0.088119	205.00

Cost Center Description		HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BLDG & FIXT-HOSP						1.01
1.02	CAP REL COSTS-BLDG & FIXT-TLMAB						1.02
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT-HOSPITAL						7.01
7.02	OPERATION OF PLANT-TLMAB						7.02
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING	1,410					9.00
10.00	DIETARY	96	10,599				10.00
11.00	CAFETERIA	0	0	16,271			11.00
13.00	NURSING ADMINISTRATION	0	0	868	170,797		13.00
14.00	CENTRAL SERVICES & SUPPLY	61	0	198	0	637,238	14.00
15.00	PHARMACY	0	0	314	0	5,006	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	526	0	1,075	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	364	10,375	3,160	65,724	38,733	30.00
31.00	INTENSIVE CARE UNIT	106	224	240	4,987	4,653	31.00
43.00	NURSERY	0	0	189	3,924	4,393	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	1,127	23,438	150,253	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	215	4,472	5,008	52.00
54.00	RADIOLOGY-DIAGNOSTIC	63	0	100	0	2,918	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	105	0	4,497	55.00
56.00	RADIOISOTOPE	0	0	229	0	1,061	56.00
57.00	CT SCAN	0	0	269	0	5,777	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	120	0	130	58.00
60.00	LABORATORY	60	0	2,416	0	262,937	60.00
66.00	PHYSICAL THERAPY	45	0	591	2,059	5,688	66.00
67.00	OCCUPATIONAL THERAPY	0	0	99	0	279	67.00
68.00	SPEECH PATHOLOGY	0	0	87	0	2,263	68.00
69.00	ELECTROCARDIOLOGY	0	0	110	2,288	2,808	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00		0	0	0	0	0	76.00
76.01	ONCOLOGY	0	0	223	4,628	4,665	76.01
76.02	CARDIOPULMONARY	33	0	842	17,517	17,489	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	59	0	359	0	3,837	90.00
91.00	EMERGENCY	150	0	1,803	37,499	60,511	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	0	0	350	0	2,914	92.01
OTHER REIMBURSABLE COST CENTERS							
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	205	0	21,908	96.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	HOME HEALTH AGENCY	21	0	1,039	4,261	3,892	101.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,058	10,599	15,784	170,797	612,695	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	117	0	101	0	0	192.00
192.01	PHYSICIANS' PRIVATE OFFICES	22	0	386	0	24,495	192.01
192.02	PHYSICIANS' PRIVATE OFFICES	213	0	0	0	0	192.02
192.03	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	40	192.03
194.00	OCCUPATIONAL MEDICINE	0	0	0	0	8	194.00
194.01	VENDING ROOM	0	0	0	0	0	194.01
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)	351,739	271,827	169,891	445,676	107,702	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	249.460284	25.646476	10.441337	2.609390	0.169014	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	81,173	40,426	32,874	11,719	46,139	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	57.569504	3.814133	2.020404	0.068614	0.072405	205.00

Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		15.00	16.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT			1.00
1.01	CAP REL COSTS-BLDG & FIXT-HOSP			1.01
1.02	CAP REL COSTS-BLDG & FIXT-TLMAB			1.02
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
7.00	OPERATION OF PLANT			7.00
7.01	OPERATION OF PLANT-HOSPITAL			7.01
7.02	OPERATION OF PLANT-TLMAB			7.02
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
13.00	NURSING ADMINISTRATION			13.00
14.00	CENTRAL SERVICES & SUPPLY			14.00
15.00	PHARMACY	100		15.00
16.00	MEDICAL RECORDS & LIBRARY	0	31,877	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	5,536	30.00
31.00	INTENSIVE CARE UNIT	0	62	31.00
43.00	NURSERY	0	289	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	2,739	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	329	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	11,304	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	RADIOISOTOPE	0	0	56.00
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	LABORATORY	0	2,068	60.00
66.00	PHYSICAL THERAPY	0	193	66.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	100	0	73.00
76.00		0	0	76.00
76.01	ONCOLOGY	0	0	76.01
76.02	CARDIOPULMONARY	0	288	76.02
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	368	90.00
91.00	EMERGENCY	0	8,701	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
OTHER REIMBURSABLE COST CENTERS				
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
101.00	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	100	31,877	118.00
NONREIMBURSABLE COST CENTERS				
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	PHYSICIANS' PRIVATE OFFICES	0	0	192.01
192.02	PHYSICIANS' PRIVATE OFFICES	0	0	192.02
192.03	PHYSICIANS' PRIVATE OFFICES	0	0	192.03
194.00	OCCUPATIONAL MEDICINE	0	0	194.00
194.01	VENDING ROOM	0	0	194.01
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)	1,220,962	187,783	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	12,209.620000	5.890862	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	73,037	24,519	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	730.370000	0.769175	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 1/24/2012 1:07 pm
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Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance		Total Costs	
			1.00	2.00		3.00	4.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,244,119		2,244,119	0	0	30.00
31.00	INTENSIVE CARE UNIT	252,301		252,301	0	0	31.00
43.00	NURSERY	106,657		106,657	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1,318,956		1,318,956	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	133,911		133,911	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	905,064		905,064	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	148,693		148,693	0	0	55.00
56.00	RADIOISOTOPE	304,574		304,574	0	0	56.00
57.00	CT SCAN	290,696		290,696	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	330,887		330,887	0	0	58.00
60.00	LABORATORY	1,148,622		1,148,622	0	0	60.00
66.00	PHYSICAL THERAPY	350,154	0	350,154	0	0	66.00
67.00	OCCUPATIONAL THERAPY	57,268	0	57,268	0	0	67.00
68.00	SPEECH PATHOLOGY	56,992	0	56,992	0	0	68.00
69.00	ELECTROCARDIOLOGY	68,138		68,138	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	5,089		5,089	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,220,962		1,220,962	0	0	73.00
76.00		0		0	0	0	76.00
76.01	ONCOLOGY	177,559		177,559	0	0	76.01
76.02	CARDIOPULMONARY	408,865		408,865	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	93,141		93,141	0	0	90.00
91.00	EMERGENCY	1,688,098		1,688,098	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0	92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	269,262		269,262	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
96.00	DURABLE MEDICAL EQUIP-RENTED	133,518		133,518	0	0	96.00
98.00	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
101.00	HOME HEALTH AGENCY	380,899		380,899	0	0	101.00
200.00	Subtotal (see instructions)	12,094,425	0	12,094,425	0	0	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	12,094,425	0	12,094,425	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151312

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

Worksheet C
Part I
Date/Time Prepared:
1/24/2012 1:07 pm

Cost Center Description	Charges			Hospital	Cost			
	Inpatient	Outpatient	Total (col. 6 + col. 7)				Cost or Other Ratio	TEFRA Inpatient Ratio
	6.00	7.00	8.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00 ADULTS & PEDIATRICS	1,696,518		1,696,518			30.00		
31.00 INTENSIVE CARE UNIT	103,330		103,330			31.00		
43.00 NURSERY	123,437		123,437			43.00		
ANCILLARY SERVICE COST CENTERS								
50.00 OPERATING ROOM	466,490	1,808,603	2,275,093	0.579737	0.000000	50.00		
52.00 DELIVERY ROOM & LABOR ROOM	140,714	0	140,714	0.951654	0.000000	52.00		
54.00 RADIOLOGY-DIAGNOSTIC	125,191	1,701,123	1,826,314	0.495569	0.000000	54.00		
55.00 RADIOLOGY-THERAPEUTIC	15,568	190,849	206,417	0.720352	0.000000	55.00		
56.00 RADIOISOTOPE	143,330	950,722	1,094,052	0.278391	0.000000	56.00		
57.00 CT SCAN	140,271	4,589,683	4,729,954	0.061459	0.000000	57.00		
58.00 MAGNETIC RESONANCE IMAGING (MRI)	51,815	703,817	755,632	0.437894	0.000000	58.00		
60.00 LABORATORY	619,179	3,161,296	3,780,475	0.303830	0.000000	60.00		
66.00 PHYSICAL THERAPY	193,835	396,315	590,150	0.593331	0.000000	66.00		
67.00 OCCUPATIONAL THERAPY	58,899	50,076	108,975	0.525515	0.000000	67.00		
68.00 SPEECH PATHOLOGY	5,646	46,275	51,921	1.097668	0.000000	68.00		
69.00 ELECTROCARDIOLOGY	48,519	610,597	659,116	0.103378	0.000000	69.00		
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00		
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	11,914	11,914	0.427145	0.000000	72.00		
73.00 DRUGS CHARGED TO PATIENTS	938,934	2,964,564	3,903,498	0.312787	0.000000	73.00		
76.00	0	0	0	0.000000	0.000000	76.00		
76.01 ONCOLOGY	199	172,857	173,056	1.026020	0.000000	76.01		
76.02 CARDIOPULMONARY	590,117	226,914	817,031	0.500428	0.000000	76.02		
OUTPATIENT SERVICE COST CENTERS								
90.00 CLINIC	10	19,608	19,618	4.747732	0.000000	90.00		
91.00 EMERGENCY	21,621	3,366,375	3,387,996	0.498259	0.000000	91.00		
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00		
92.01 OBSERVATION BEDS (DISTINCT PART)	4	437,591	437,595	0.615322	0.000000	92.01		
OTHER REIMBURSABLE COST CENTERS								
96.00 DURABLE MEDICAL EQUIP-RENTED	0	188,045	188,045	0.710032	0.000000	96.00		
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00		
101.00 HOME HEALTH AGENCY	0	0	0			101.00		
200.00 Subtotal (see instructions)	5,483,627	21,597,224	27,080,851			200.00		
201.00 Less Observation Beds						201.00		
202.00 Total (see instructions)	5,483,627	21,597,224	27,080,851			202.00		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151312

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

Worksheet C
Part I
Date/Time Prepared:
1/24/2012 1:07 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	RADIOISOTOPE	0.000000			56.00
57.00	CT SCAN	0.000000			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	LABORATORY	0.000000			60.00
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00		0.000000			76.00
76.01	ONCOLOGY	0.000000			76.01
76.02	CARDIOPULMONARY	0.000000			76.02
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.000000			90.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	0.000000			92.01
OTHER REIMBURSABLE COST CENTERS					
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000			98.00
101.00	HOME HEALTH AGENCY				101.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 1/24/2012 1:07 pm
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Cost Center Description	Title XVIII			Hospital	Cost		
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	351,388	2,275,093	0.154450	102,667	15,857	50.00
52.00	DELIVERY ROOM & LABOR ROOM	25,778	140,714	0.183194	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	225,373	1,826,314	0.123403	107,311	13,242	54.00
55.00	RADIOLOGY-THERAPEUTIC	15,041	206,417	0.072867	5,901	430	55.00
56.00	RADIOISOTOPE	16,357	1,094,052	0.014951	15,746	235	56.00
57.00	CT SCAN	20,357	4,729,954	0.004304	86,838	374	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	6,113	755,632	0.008090	49,053	397	58.00
60.00	LABORATORY	129,460	3,780,475	0.034244	293,686	10,057	60.00
66.00	PHYSICAL THERAPY	85,058	590,150	0.144129	54,777	7,895	66.00
67.00	OCCUPATIONAL THERAPY	1,219	108,975	0.011186	16,301	182	67.00
68.00	SPEECH PATHOLOGY	1,331	51,921	0.025635	2,558	66	68.00
69.00	ELECTROCARDIOLOGY	13,869	659,116	0.021042	26,466	557	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	91	11,914	0.007638	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	73,037	3,903,498	0.018711	436,565	8,169	73.00
76.00		0	0	0.000000	0	0	76.00
76.01	ONCOLOGY	58,182	173,056	0.336203	44	15	76.01
76.02	CARDIOPULMONARY	58,365	817,031	0.071435	311,963	22,285	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	5,961	19,618	0.303854	2	1	90.00
91.00	EMERGENCY	286,632	3,387,996	0.084602	2,213	187	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	117,540	437,595	0.268605	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
96.00	DURABLE MEDICAL EQUIP-RENTED	26,200	188,045	0.139328	0	0	96.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50-199)	1,517,352	25,157,566		1,512,091	79,949	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151312

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

Worksheet D
Part IV
Date/Time Prepared:
1/24/2012 1:07 pm

Cost Center Description	Title XVIII				Hospital	Cost	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All other Medical Education Cost	Total Cost (sum of col 1 through col. 4)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	0	0	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
60.00 LABORATORY	0	0	0	0	0	0	60.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	0	0	0	0	0	0	76.00
76.01 ONCOLOGY	0	0	0	0	0	0	76.01
76.02 CARDIOPULMONARY	0	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00 CLINIC	0	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
92.01 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0	96.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/24/2012 1:07 pm
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Cost Center Description	Title XVIII					Hospital		
	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient	Cost		
	Outpatient Cost (sum of col. 2, 3 and 4)	(from wkst. C, Part I, col. 8)	to Charges (col. 5 ÷ col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)	Program Charges			
6.00	7.00	8.00	9.00	10.00				
ANCILLARY SERVICE COST CENTERS								
50.00 OPERATING ROOM	0	2,275,093	0.000000	0.000000	102,667	50.00		
52.00 DELIVERY ROOM & LABOR ROOM	0	140,714	0.000000	0.000000	0	52.00		
54.00 RADIOLOGY-DIAGNOSTIC	0	1,826,314	0.000000	0.000000	107,311	54.00		
55.00 RADIOLOGY-THERAPEUTIC	0	206,417	0.000000	0.000000	5,901	55.00		
56.00 RADIOISOTOPE	0	1,094,052	0.000000	0.000000	15,746	56.00		
57.00 CT SCAN	0	4,729,954	0.000000	0.000000	86,838	57.00		
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	755,632	0.000000	0.000000	49,053	58.00		
60.00 LABORATORY	0	3,780,475	0.000000	0.000000	293,686	60.00		
66.00 PHYSICAL THERAPY	0	590,150	0.000000	0.000000	54,777	66.00		
67.00 OCCUPATIONAL THERAPY	0	108,975	0.000000	0.000000	16,301	67.00		
68.00 SPEECH PATHOLOGY	0	51,921	0.000000	0.000000	2,558	68.00		
69.00 ELECTROCARDIOLOGY	0	659,116	0.000000	0.000000	26,466	69.00		
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00		
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	11,914	0.000000	0.000000	0	72.00		
73.00 DRUGS CHARGED TO PATIENTS	0	3,903,498	0.000000	0.000000	436,565	73.00		
76.00	0	0	0.000000	0.000000	0	76.00		
76.01 ONCOLOGY	0	173,056	0.000000	0.000000	44	76.01		
76.02 CARDIOPULMONARY	0	817,031	0.000000	0.000000	311,963	76.02		
OUTPATIENT SERVICE COST CENTERS								
90.00 CLINIC	0	19,618	0.000000	0.000000	2	90.00		
91.00 EMERGENCY	0	3,387,996	0.000000	0.000000	2,213	91.00		
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00		
92.01 OBSERVATION BEDS (DISTINCT PART)	0	437,595	0.000000	0.000000	0	92.01		
OTHER REIMBURSABLE COST CENTERS								
96.00 DURABLE MEDICAL EQUIP-RENTED	0	188,045	0.000000	0.000000	0	96.00		
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00		
200.00 Total (lines 50-199)	0	25,157,566			1,512,091	200.00		

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151312

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

Worksheet D
Part IV
Date/Time Prepared:
1/24/2012 1:07 pm

Cost Center Description	Title XVIII			Hospital		Cost
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist 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
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 LABORATORY	0	0	0	0	0	60.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	0	0	0	0	0	76.00
76.01 ONCOLOGY	0	0	0	0	0	76.01
76.02 CARDIOPULMONARY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/24/2012 1:07 pm
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0			50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0			52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0			54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0			55.00
56.00	RADIOISOTOPE	0	0			56.00
57.00	CT SCAN	0	0			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
60.00	LABORATORY	0	0			60.00
66.00	PHYSICAL THERAPY	0	0			66.00
67.00	OCCUPATIONAL THERAPY	0	0			67.00
68.00	SPEECH PATHOLOGY	0	0			68.00
69.00	ELECTROCARDIOLOGY	0	0			69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0			73.00
76.00		0	0			76.00
76.01	ONCOLOGY	0	0			76.01
76.02	CARDIOPULMONARY	0	0			76.02
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0			90.00
91.00	EMERGENCY	0	0			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	0	0			92.01
OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0			96.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0			98.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/24/2012 1:07 pm
Title XVIII		Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges		Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	Cost
			Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0.579737	0	596,387	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.951654	0	0	0		52.00
54.00 RADIOLOGY-DIAGNOSTIC	0.495569	0	709,825	0		54.00
55.00 RADIOLOGY-THERAPEUTIC	0.720352	0	101,753	0		55.00
56.00 RADIOISOTOPE	0.278391	0	74,570	0		56.00
57.00 CT SCAN	0.061459	0	1,619,412	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.437894	0	277,702	0		58.00
60.00 LABORATORY	0.303830	0	1,141,904	0		60.00
66.00 PHYSICAL THERAPY	0.593331	0	174,169	0		66.00
67.00 OCCUPATIONAL THERAPY	0.525515	0	24,373	0		67.00
68.00 SPEECH PATHOLOGY	1.097668	0	14,570	0		68.00
69.00 ELECTROCARDIOLOGY	0.103378	0	198,842	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.427145	0	6,781	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.312787	0	1,518,971	608		73.00
76.00	0.000000	0	0	0		76.00
76.01 ONCOLOGY	1.026020	0	73,447	0		76.01
76.02 CARDIOPULMONARY	0.500428	0	125,265	0		76.02
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	4.747732	0	3,588	0		90.00
91.00 EMERGENCY	0.498259	0	931,129	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0		92.00
92.01 OBSERVATION BEDS (DISTINCT PART)	0.615322	0	235,561	0		92.01
OTHER REIMBURSABLE COST CENTERS						
96.00 DURABLE MEDICAL EQUIP-RENTED	0.710032	0	0	0		96.00
98.00 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0		98.00
200.00 Subtotal (see instructions)		0	7,828,249	608		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	7,828,249	608		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/24/2012 1:07 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			Hospital	Cost
	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	345,748	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	351,767	0		54.00
55.00 RADIOLOGY-THERAPEUTIC	0	73,298	0		55.00
56.00 RADIOISOTOPE	0	20,760	0		56.00
57.00 CT SCAN	0	99,527	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	121,604	0		58.00
60.00 LABORATORY	0	346,945	0		60.00
66.00 PHYSICAL THERAPY	0	103,340	0		66.00
67.00 OCCUPATIONAL THERAPY	0	12,808	0		67.00
68.00 SPEECH PATHOLOGY	0	15,993	0		68.00
69.00 ELECTROCARDIOLOGY	0	20,556	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	2,896	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	475,114	190		73.00
76.00	0	0	0		76.00
76.01 ONCOLOGY	0	75,358	0		76.01
76.02 CARDIOPULMONARY	0	62,686	0		76.02
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0	17,035	0		90.00
91.00 EMERGENCY	0	463,943	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
92.01 OBSERVATION BEDS (DISTINCT PART)	0	144,946	0		92.01
OTHER REIMBURSABLE COST CENTERS					
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00 Subtotal (see instructions)	0	2,754,324	190		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	2,754,324	190		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151312 Component CCN:15Z312	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/24/2012 1:07 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.579737	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.951654	0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.495569	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.720352	0	0	0	55.00
56.00	RADIOISOTOPE	0.278391	0	0	0	56.00
57.00	CT SCAN	0.061459	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.437894	0	0	0	58.00
60.00	LABORATORY	0.303830	0	0	0	60.00
66.00	PHYSICAL THERAPY	0.593331	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.525515	0	0	0	67.00
68.00	SPEECH PATHOLOGY	1.097668	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.103378	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.427145	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.312787	0	0	0	73.00
76.00		0.000000	0	0	0	76.00
76.01	ONCOLOGY	1.026020	0	0	0	76.01
76.02	CARDIOPULMONARY	0.500428	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	4.747732	0	0	0	90.00
91.00	EMERGENCY	0.498259	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	0.615322	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0.710032	0	0	0	96.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	98.00
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: 151312 Component CCN:152312	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/24/2012 1:07 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs			
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)	
	5.00	6.00	7.00	
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	56.00
57.00 CT SCAN	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
60.00 LABORATORY	0	0	0	60.00
66.00 PHYSICAL THERAPY	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	0	0	0	76.00
76.01 ONCOLOGY	0	0	0	76.01
76.02 CARDIOPULMONARY	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS				
90.00 CLINIC	0	0	0	90.00
91.00 EMERGENCY	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
92.01 OBSERVATION BEDS (DISTINCT PART)	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS				
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
200.00 Subtotal (see instructions)	0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet D-1
Date/Time Prepared: 1/24/2012 1:07 pm		Title XVIII	Hospital	Cost
Cost Center Description				
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,427	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,763	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)		1,763	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		604	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		60	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)		1,065	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)		579	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		145.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,244,119	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)		8,700	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)		579,124	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,664,995	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,696,518	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,696,518	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.981419	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)		962.29	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)		1,664,995	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)		944.41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,005,797	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,005,797	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	worksheet D-1 Date/Time Prepared: 1/24/2012 1:07 pm
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Cost Center Description	Title XVIII			Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00
Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0
43.00 INTENSIVE CARE UNIT	252,301	68	3,710.31	36	133,571
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					577,818
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,717,186
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
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					0
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
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
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
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)					546,813
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					546,813
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
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
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00 Program routine service cost (line 9 x line 71)					
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)					
76.00 Per diem capital-related costs (line 75 ÷ line 2)					
77.00 Program capital-related costs (line 9 x line 76)					
78.00 Inpatient routine service cost (line 74 minus line 77)					
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00 Inpatient routine service cost per diem limitation					
82.00 Inpatient routine service cost limitation (line 9 x line 81)					
83.00 Reasonable inpatient routine service costs (see instructions)					
84.00 Program inpatient ancillary services (see instructions)					
85.00 Utilization review - physician compensation (see instructions)					
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/24/2012 1:07 pm
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Cost Center Description	Cost	Title XVIII		Hospital	Cost	
		Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	0	0	0.000000	0	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/24/2012 1:07 pm
	Title XIX	Hospital	Cost

Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,427	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,763	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)	1,763	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)	107	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)	257	15.00
16.00	Nursery days (title V or XIX only)	179	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	0	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)	0	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,696,518	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,696,518	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	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)	962.29	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)	0	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)	0.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/24/2012 1:07 pm
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Cost Center Description	Title XIX		Hospital		Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	
	0	257	0.00	179	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	68	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/24/2012 1:07 pm
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Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Hospital	
				Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
	1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
90.00 Capital-related cost	0	0	0.000000	0	0 90.00
91.00 Nursing School cost	0	0	0.000000	0	0 91.00
92.00 Allied health cost	0	0	0.000000	0	0 92.00
93.00 All other Medical Education	0	0	0.000000	0	0 93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/24/2012 1:07 pm
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Cost Center Description		Title XVIII	Hospital	Cost
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		732,108	30.00
31.00	INTENSIVE CARE UNIT		42,351	31.00
43.00	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.579737	102,667	59,520 50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.951654	0	0 52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.495569	107,311	53,180 54.00
55.00	RADIOLOGY-THERAPEUTIC	0.720352	5,901	4,251 55.00
56.00	RADIOISOTOPE	0.278391	15,746	4,384 56.00
57.00	CT SCAN	0.061459	86,838	5,337 57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.437894	49,053	21,480 58.00
60.00	LABORATORY	0.303830	293,686	89,231 60.00
66.00	PHYSICAL THERAPY	0.593331	54,777	32,501 66.00
67.00	OCCUPATIONAL THERAPY	0.525515	16,301	8,566 67.00
68.00	SPEECH PATHOLOGY	1.097668	2,558	2,808 68.00
69.00	ELECTROCARDIOLOGY	0.103378	26,466	2,736 69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0 71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.427145	0	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	0.312787	436,565	136,552 73.00
76.00		0.000000	0	0 76.00
76.01	ONCOLOGY	1.026020	44	45 76.01
76.02	CARDIOPULMONARY	0.500428	311,963	156,115 76.02
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	4.747732	2	9 90.00
91.00	EMERGENCY	0.498259	2,213	1,103 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0 92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	0.615322	0	0 92.01
OTHER REIMBURSABLE COST CENTERS				
96.00	DURABLE MEDICAL EQUIP-RENTED	0.710032	0	0 96.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0 98.00
200.00	Total (sum of lines 50-94 and 96-98)		1,512,091	577,818 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net Charges (line 200 minus line 201)		1,512,091	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet D-3	
		Component CCN:15Z312		Date/Time Prepared: 1/24/2012 1:07 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		202,300		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.579737	23,084	13,383	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.951654	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.495569	16,247	8,052	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.720352	1,309	943	55.00
56.00	RADIOISOTOPE	0.278391	2,107	587	56.00
57.00	CT SCAN	0.061459	8,165	502	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.437894	2,762	1,209	58.00
60.00	LABORATORY	0.303830	63,790	19,381	60.00
66.00	PHYSICAL THERAPY	0.593331	109,075	64,718	66.00
67.00	OCCUPATIONAL THERAPY	0.525515	34,954	18,369	67.00
68.00	SPEECH PATHOLOGY	1.097668	1,603	1,760	68.00
69.00	ELECTROCARDIOLOGY	0.103378	4,554	471	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.427145	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.312787	178,595	55,862	73.00
76.00		0.000000	0	0	76.00
76.01	ONCOLOGY	1.026020	155	159	76.01
76.02	CARDIOPULMONARY	0.500428	135,811	67,964	76.02
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	4.747732	8	38	90.00
91.00	EMERGENCY	0.498259	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	0.615322	4	2	92.01
OTHER REIMBURSABLE COST CENTERS					
96.00	DURABLE MEDICAL EQUIP-RENTED	0.710032	0	0	96.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		582,223	253,400	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		582,223		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/24/2012 1:07 pm
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Cost Center Description	Title XIX		Hospital		Cost
	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)		
	1.00	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS		57,872			30.00
31.00 INTENSIVE CARE UNIT		4,181			31.00
43.00 NURSERY		40,891			43.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.000000	50,504	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0.000000	1,633	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
56.00 RADIOISOTOPE	0.000000	2,721	0	0	56.00
57.00 CT SCAN	0.000000	4,612	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
60.00 LABORATORY	0.000000	27,298	0	0	60.00
66.00 PHYSICAL THERAPY	0.000000	379	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0.000000	125	0	0	67.00
68.00 SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0.000000	503	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.000000	23,504	0	0	73.00
76.00 ONCOLOGY	0.000000	0	0	0	76.00
76.01 ONCOLOGY	0.000000	0	0	0	76.01
76.02 CARDIOPULMONARY	0.000000	2,994	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0.000000	0	0	0	90.00
91.00 EMERGENCY	0.000000	4,104	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
92.01 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
96.00 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	96.00
98.00 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	98.00
200.00 Total (sum of lines 50-94 and 96-98)		118,377	0	0	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	0	201.00
202.00 Net Charges (line 200 minus line 201)		118,377	0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/24/2012 1:07 pm
	Title XVIII	Hospital	Cost

			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,754,514	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)		2,754,514	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		2,782,059	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)		48,453	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,321,260	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)		1,412,346	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)		1,412,346	30.00
31.00	Primary payer payments		678	31.00
32.00	Subtotal (line 30 minus line 31)		1,411,668	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)		216,901	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		216,901	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		195,502	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		1,628,569	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)		1,628,569	40.00
41.00	Interim payments		1,732,549	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)		-103,980	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: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/24/2012 1:07 pm
	Title XVIII	Hospital	Cost
			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: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet E-1 Part I Date/Time Prepared: 1/24/2012 1:07 pm
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		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,684,836		1,841,928	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	06/30/2011	40,742	06/30/2011	212,030	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	08/25/2011	295,747	08/21/2011	321,409	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)		-255,005		-109,379	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		1,429,831		1,732,549	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		104,880		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		103,980	6.02	
7.00	Total Medicare program liability (see instructions)		1,534,711		1,628,569	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: 151312

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

Worksheet E-1
Part I
Date/Time Prepared:
1/24/2012 1:07 pm

		Title XVIII		Swing Beds - SNF		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		867,461		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		150,041		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)		-150,041		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)		717,420		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		79,333		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		796,753		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: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet E-2
	Component CCN: 15Z312		Date/Time Prepared: 1/24/2012 1:07 pm

		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)	552,281	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)	255,934	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	579	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)	808,215	0		8.00
9.00	Primary payer payments (see instructions)	0	0		9.00
10.00	Subtotal (line 8 minus line 9)	808,215	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)	808,215	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	11,462	0		13.00
14.00	80% of Part B costs (line 12 x 80%)				14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	796,753	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)	796,753	0		19.00
20.00	Interim payments	717,420	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)	79,333	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0		23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet E-3 Part V Date/Time Prepared: 1/24/2012 1:07 pm
	Title XVIII	Hospital	Cost

			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)				
1.00	Inpatient services		1,717,186	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)		1,717,186	4.00
5.00	Primary payer payments		502	5.00
6.00	Total cost (line 5 less line 6) . For CAH (see instructions)		1,733,856	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)		1,733,856	19.00
20.00	Deductibles (exclude professional component)		243,267	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus sum of lines 20 and 21)		1,490,589	22.00
23.00	Coinsurance		3,396	23.00
24.00	Subtotal (line 22 minus line 23)		1,487,193	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		47,518	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		47,518	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		41,570	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26(line 26 hospital and subprovider only))		1,534,711	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)		1,534,711	30.00
31.00	Interim payments		1,429,831	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)		104,880	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 1/24/2012 1:07 pm
	Title XIX	Hospital	Cost

1.00

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES

COMPUTATION OF NET COST OF COVERED SERVICES

1.00	Inpatient hospital/SNF/NF services	0	1.00
2.00	Medical and other services	0	2.00
3.00	Organ acquisition (certified transplant centers only)	0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	4.00
5.00	Inpatient primary payer payments	0	5.00
6.00	Outpatient primary payer payments	0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	7.00

COMPUTATION OF LESSER OF COST OR CHARGES

Reasonable Charges

8.00	Routine service charges	102,944	8.00
9.00	Ancillary service charges	118,377	9.00
10.00	Organ acquisition charges, net of revenue	0	10.00
11.00	Incentive from target amount computation	0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	221,321	12.00

CUSTOMARY CHRGES

13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	15.00
16.00	Total customary charges (see instructions)	221,321	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 7) (see instructions)	221,321	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 7 exceeds line 16) (see instructions)	0	18.00
19.00	Interns and Residents (see instructions)	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	20.00
21.00	Cost of covered services (line 7)	0	21.00

PROSPECTIVE PAYMENT AMOUNT

22.00	Other than outlier payments	0	22.00
23.00	Outlier payments	0	23.00
24.00	Program capital payments	0	24.00
25.00	Capital exception payments (see instructions)	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	26.00
27.00	Subtotal (sum of lines 22 through 26, plus line 3 minus lines 5 and 6)	0	27.00
28.00	Customary charges (title XIX PPS covered services only)	0	28.00
29.00	Titles V or XIX (see instructions)	0	29.00

COMPUTATION OF REIMBURSEMENT SETTLEMENT

30.00	Excess of reasonable cost (from line 18)	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus line 29 minus line 30)	0	31.00
32.00	Deductibles	0	32.00
33.00	Coinsurance	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Utilization review	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	38.00
39.00	Direct graduate medical education payments (from wkst. E-4)	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	40.00
41.00	Interim payments	71,589	41.00
42.00	Balance due provider/program (line 40 minus 41)	-71,589	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	43.00

Health Financial Systems

In Lieu of Form CMS-2552-10

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

Provider CCN: 151312

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

Worksheet G

Date/Time Prepared:
1/24/2012 1:07 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	3,706,884	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	10,142,861	0	0	0	4.00
5.00	Other receivable	64,560	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,750,417	0	0	0	6.00
7.00	Inventory	635,901	0	0	0	7.00
8.00	Prepaid expenses	205,938	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,005,727	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	42,382,940	0	0	0	15.00
16.00	Accumulated depreciation	-9,049,264	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)	33,333,676	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,536,778	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,536,778	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	44,876,181	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	336,557	0	0	0	37.00
38.00	Salaries, wages, and fees payable	690,210	0	0	0	38.00
39.00	Payroll taxes payable	384,643	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	982,543	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,393,953	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	2,216,720	0	0	0	46.00
47.00	Notes payable	32,729,581	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)	34,946,301	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	37,340,254	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	7,535,927	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	7,535,927	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	44,876,181	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151312

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

Worksheet G-1
Date/Time Prepared:
1/24/2012 1:07 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
1.00	Fund balances at beginning of period		8,245,117		0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		-965,969			2.00
3.00	Total (sum of line 1 and line 2)		7,279,148		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)		7,279,148		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)		7,279,148		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151312

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

Worksheet G-1

Date/Time Prepared:
1/24/2012 1:07 pm

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

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,716,077		1,716,077	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,716,077		1,716,077	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	85,891		85,891	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)	85,891		85,891	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,801,968		1,801,968	17.00
18.00	Ancillary services	3,378,797	0	3,378,797	18.00
19.00	Outpatient services	0	22,820,635	22,820,635	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		0	0	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				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	5,180,765	22,820,635	28,001,400	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		14,379,297		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		14,379,297		43.00

Health Financial Systems

In Lieu of Form CMS-2552-10

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 1/24/2012 1:07 pm
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		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	28,001,400	1.00
2.00	Less contractual allowances and discounts on patients' accounts	12,526,271	2.00
3.00	Net patient revenues (line 1 minus line 2)	15,475,129	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	14,379,297	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,095,832	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	43,430	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 OPERATING REVENUE	537,702	24.00
24.01	INTEREST & RENTAL INCOME	58,819	24.01
24.02	MISC	4,248	24.02
25.00	Total other income (sum of lines 6-24)	644,199	25.00
26.00	Total (line 5 plus line 25)	1,740,031	26.00
27.00	SWAP	569,586	27.00
27.01	BAD DEBT	2,136,414	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	2,706,000	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-965,969	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151312

Period: From 01/01/2011

Worksheet H

HHA CCN: 157514

To 06/30/2011

Date/Time Prepared: 1/24/2012 1:07 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures		0		0	1.00
2.00	Capital Related - Movable Equipment		0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	48,748	0	0	49,111	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	49,039	0	0	0	6.00
7.00	Physical Therapy	51,162	0	0	0	7.00
8.00	Occupational Therapy	1,039	0	0	0	8.00
9.00	Speech Pathology	1,745	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	10.00
11.00	Home Health Aide	35,021	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	3,637	0	0	0	22.00
23.00	All Others (specify)	6,822	0	0	0	23.00
24.00	Total (sum of lines 1-23)	197,213	0	0	49,111	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: 151312	Period: From 01/01/2011 To 06/30/2011	worksheet H
		HHA CCN: 157514		Date/Time Prepared: 1/24/2012 1:07 pm
			Home Health Agency I	PPS

	Total (sum of cols. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
	6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	97,859	0	97,859	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	49,039	0	49,039	0	6.00
7.00	Physical Therapy	51,162	0	51,162	0	7.00
8.00	Occupational Therapy	1,039	0	1,039	0	8.00
9.00	Speech Pathology	1,745	0	1,745	0	9.00
10.00	Medical Social Services	0	0	0	0	10.00
11.00	Home Health Aide	35,021	0	35,021	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	3,637	0	3,637	0	22.00
23.00	All others (specify)	6,822	0	6,822	0	23.00
24.00	Total (sum of lines 1-23)	246,324	0	246,324	0	24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet H-1 Part I Date/Time Prepared: 1/24/2012 1:07 pm
		HHA CCN: 157514	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs			Plant Operation & Maintenance	Transportation	
		Bldgs & Fixtures	Movable Equipment				
		1.00	2.00	3.00			
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	97,859	0	0	0	0	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	49,039	0	0	0	0	6.00
7.00	Physical Therapy	51,162	0	0	0	0	7.00
8.00	Occupational Therapy	1,039	0	0	0	0	8.00
9.00	Speech Pathology	1,745	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	35,021	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	3,637	0	0	0	0	22.00
23.00	All Others (specify)	6,822	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	246,324	0	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet H-1 Part I Date/Time Prepared: 1/24/2012 1:07 pm
		HHA CCN: 157514	Home Health Agency I	PPS

		Subtotal (cols. 0-4) 4A.00	Administrative & General 5.00	Total (cols. 4A + 5) 6.00	
GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0			1.00
2.00	Capital Related - Movable Equipment	0			2.00
3.00	Plant Operation & Maintenance	0			3.00
4.00	Transportation				4.00
5.00	Administrative and General	97,859	97,859		5.00
HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	49,039	32,324	81,363	6.00
7.00	Physical Therapy	51,162	33,722	84,884	7.00
8.00	Occupational Therapy	1,039	685	1,724	8.00
9.00	Speech Pathology	1,745	1,150	2,895	9.00
10.00	Medical Social Services	0	0	0	10.00
11.00	Home Health Aide	35,021	23,084	58,105	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	3,637	2,397	6,034	22.00
23.00	All Others (specify)	6,822	4,497	11,319	23.00
24.00	Total (sum of lines 1-23)	148,465		246,324	24.00

COST ALLOCATION - HHA STATISTICAL BASIS	Provider CCN: 151312	Period:	Worksheet H-1
	HHA CCN: 157514	From 01/01/2011 To 06/30/2011	Part II Date/Time Prepared: 1/24/2012 1:07 pm
		Home Health Agency I	PPS

	Capital Related Costs					Reconciliation	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)			
	1.00	2.00	3.00	4.00	5A.00		
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0	0	-97,859	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-97,859	24.00
25.00	Cost To Be Allocated (per worksheet H-1, Part I)	0	0	0	0	0	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	26.00

Health Financial Systems

In Lieu of Form CMS-2552-10

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet H-1 Part II Date/Time Prepared: 1/24/2012 1:07 pm
		HHA CCN: 157514	Home Health Agency I	PPS

		Administrative & General (ACCUM. COST)	
		5.00	
GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures		1.00
2.00	Capital Related - Movable Equipment		2.00
3.00	Plant Operation & Maintenance		3.00
4.00	Transportation (see instructions)		4.00
5.00	Administrative and General	148,465	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	49,039	6.00
7.00	Physical Therapy	51,162	7.00
8.00	Occupational Therapy	1,039	8.00
9.00	Speech Pathology	1,745	9.00
10.00	Medical Social Services	0	10.00
11.00	Home Health Aide	35,021	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	3,637	22.00
23.00	All Others (specify)	6,822	23.00
24.00	Total (sum of lines 1-23)	148,465	24.00
25.00	Cost To Be Allocated (per worksheet H-1, Part I)	97,859	25.00
26.00	Unit Cost Multiplier	0.659139	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151312

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

worksheet H-2
Part I
Date/Time Prepared:
1/24/2012 1:07 pm

HHA CCN: 157514

Home Health
Agency I

PPS

	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	
		BLDG & FIXT	BLDG & FIXT-HOSP	BLDG & FIXT-TLMAB		
	0	1.00	1.01	1.02	4.00	
1.00 Administrative and General	0	677	0	10,945	10,363	1.00
2.00 Skilled Nursing Care	81,363	0	0	0	10,425	2.00
3.00 Physical Therapy	84,884	0	0	0	10,878	3.00
4.00 Occupational Therapy	1,724	0	0	0	221	4.00
5.00 Speech Pathology	2,895	0	0	0	371	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	58,105	0	0	0	7,445	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	6,034	0	0	0	773	18.00
19.00 All Others (specify)	11,319	0	0	0	1,450	19.00
20.00 Total (sum of lines 1-19) (2)	246,324	677	0	10,945	41,926	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: 151312

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

Worksheet H-2
Part I
Date/Time Prepared:
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HHA CCN: 157514

Home Health
Agency I

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		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-HOSPITAL	OPERATION OF PLANT-TLMAB	
		4A	5.00	7.00	7.01	7.02	
1.00	Administrative and General	21,985	3,564	1,131	0	3,418	1.00
2.00	Skilled Nursing Care	91,788	14,880	0	0	0	2.00
3.00	Physical Therapy	95,762	15,524	0	0	0	3.00
4.00	Occupational Therapy	1,945	315	0	0	0	4.00
5.00	Speech Pathology	3,266	529	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	65,550	10,627	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	6,807	1,104	0	0	0	18.00
19.00	All others (specify)	12,769	2,070	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	299,872	48,613	1,131	0	3,418	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: 151312

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

Worksheet H-2
Part I
Date/Time Prepared:
1/24/2012 1:07 pm

HHA CCN: 157514

Home Health
Agency I

PPS

	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	0	5,239	0	10,849	11,119	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	0	5,239	0	10,849	11,119	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: 151312 HHA CCN: 157514	Period: From 01/01/2011 To 06/30/2011	worksheet H-2 Part I Date/Time Prepared: 1/24/2012 1:07 pm
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		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Home Health Agency I	Intern & Residents Cost & Post Stepdown Adjustments	PPS
		14.00	15.00	16.00	24.00		25.00	
1.00	Administrative and General	658	0	0	57,963		0	1.00
2.00	Skilled Nursing Care	0	0	0	106,668		0	2.00
3.00	Physical Therapy	0	0	0	111,286		0	3.00
4.00	Occupational Therapy	0	0	0	2,260		0	4.00
5.00	Speech Pathology	0	0	0	3,795		0	5.00
6.00	Medical Social Services	0	0	0	0		0	6.00
7.00	Home Health Aide	0	0	0	76,177		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	7,911		0	18.00
19.00	All Others (specify)	0	0	0	14,839		0	19.00
20.00	Total (sum of lines 1-19) (2)	658	0	0	380,899		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: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet H-2 Part I Date/Time Prepared: 1/24/2012 1:07 pm
		HHA CCN: 157514	Home Health Agency I	PPS

		Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		26.00	27.00	28.00	
1.00	Administrative and General	57,963			1.00
2.00	Skilled Nursing Care	106,668	19,146	125,814	2.00
3.00	Physical Therapy	111,286	19,974	131,260	3.00
4.00	Occupational Therapy	2,260	406	2,666	4.00
5.00	Speech Pathology	3,795	681	4,476	5.00
6.00	Medical Social Services	0	0	0	6.00
7.00	Home Health Aide	76,177	13,673	89,850	7.00
8.00	Supplies (see instructions)	0	0	0	8.00
9.00	Drugs	0	0	0	9.00
10.00	DME	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	13.00
14.00	Clinic	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	15.00
16.00	Day Care Program	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	17.00
18.00	Homemaker Service	7,911	1,420	9,331	18.00
19.00	All Others (specify)	14,839	2,663	17,502	19.00
20.00	Total (sum of lines 1-19) (2)	380,899	57,963	380,899	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.		0.179488		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: 151312	Period: From 01/01/2011	worksheet H-2 Part II Date/Time Prepared: 1/24/2012 1:07 pm
	HHA CCN: 157514	To 06/30/2011	
		Home Health Agency I	PPS

		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
		BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-HOSP (SQUARE FEET)	BLDG & FIXT-TLMAB (SQUARE FEET)			
		1.00	1.01	1.02	4.00	5A	
1.00	Administrative and General	940	0	940	48,748	0	1.00
2.00	Skilled Nursing Care	0	0	0	49,039	0	2.00
3.00	Physical Therapy	0	0	0	51,162	0	3.00
4.00	Occupational Therapy	0	0	0	1,039	0	4.00
5.00	Speech Pathology	0	0	0	1,745	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	35,021	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	3,637	0	18.00
19.00	All Others (specify)	0	0	0	6,822	0	19.00
20.00	Total (sum of lines 1-19)	940	0	940	197,213		20.00
21.00	Total cost to be allocated	677	0	10,945	41,926		21.00
22.00	Unit cost multiplier	0.720213	0.000000	11.643617	0.212592		22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet H-2 Part II
	HHA CCN: 157514		Date/Time Prepared: 1/24/2012 1:07 pm
		Home Health Agency I	PPS

	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-HOSPITAL (SQUARE FEET)	OPERATION OF PLANT-TLMAB (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
	5.00	7.00	7.01	7.02	8.00	
1.00 Administrative and General	21,985	940	0	940	0	1.00
2.00 Skilled Nursing Care	91,788	0	0	0	0	2.00
3.00 Physical Therapy	95,762	0	0	0	0	3.00
4.00 Occupational Therapy	1,945	0	0	0	0	4.00
5.00 Speech Pathology	3,266	0	0	0	0	5.00
6.00 Medical social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	65,550	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	6,807	0	0	0	0	18.00
19.00 All Others (specify)	12,769	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	299,872	940	0	940	0	20.00
21.00 Total cost to be allocated	48,613	1,131	0	3,418	0	21.00
22.00 Unit cost multiplier	0.162113	1.203191	0.000000	3.636170	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS
 Provider CCN: 151312
 HHA CCN: 157514
 Period: From 01/01/2011 To 06/30/2011
 Worksheet H-2 Part II
 Date/Time Prepared: 1/24/2012 1:07 pm

		Home Health Agency I		PPS			
	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)		
	9.00	10.00	11.00	13.00	14.00		
1.00	Administrative and General	21	0	1,039	4,261	3,892	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	21	0	1,039	4,261	3,892	20.00
21.00	Total cost to be allocated	5,239	0	10,849	11,119	658	21.00
22.00	Unit cost multiplier	249.476190	0.000000	10.441771	2.609481	0.169065	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet H-2 Part II
	HHA CCN: 157514	Home Health Agency I	Date/Time Prepared: 1/24/2012 1:07 pm PPS

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

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet H-3 Parts I-II Date/Time Prepared: 1/24/2012 1:07 pm
		HHA CCN: 157514		

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	125,814		125,814	1,061
2.00	Physical Therapy	3.00	131,260	0	131,260	912
3.00	Occupational Therapy	4.00	2,666	0	2,666	13
4.00	Speech Pathology	5.00	4,476	0	4,476	20
5.00	Medical Social Services	6.00	0		0	0
6.00	Home Health Aide	7.00	89,850		89,850	1,528
7.00	Total (sum of lines 1-6)		354,066	0	354,066	3,534

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

Limitation Cost Computation						
8.00	Skilled Nursing Care		99915	0	0	8.00
9.00	Physical Therapy		99915	0	0	9.00
10.00	Occupational Therapy		99915	0	0	10.00
11.00	Speech Pathology		99915	0	0	11.00
12.00	Medical Social Services		99915	0	0	12.00
13.00	Home Health Aide		99915	0	0	13.00
14.00	Total (sum of lines 8-13)			0	0	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	902
16.00	Cost of Drugs	9.00	0	0	0	0

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

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy		66.00	0.593331	0	1.00
2.00	Occupational Therapy		67.00	0.525515	0	2.00
3.00	Speech Pathology		68.00	1.097668	0	3.00
4.00	Cost of Medical Supplies		71.00	0.000000	0	4.00
5.00	Cost of Drugs		73.00	0.312787	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS	Provider CCN: 151312 HHA CCN: 157514	Period: From 01/01/2011 To 06/30/2011	Worksheet H-3 Parts I-II Date/Time Prepared: 1/24/2012 1:07 pm
	Title XVIII	Home Health Agency I	PPS

Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Program Visits		9.00	
		Part A	Part B		
			Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance
	5.00	6.00	7.00	8.00	

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

Cost Per Visit Computation						
1.00	Skilled Nursing Care	118.58	478	325	1.00	
2.00	Physical Therapy	143.93	457	260	2.00	
3.00	Occupational Therapy	205.08	0	10	3.00	
4.00	Speech Pathology	223.80	1	0	4.00	
5.00	Medical Social Services	0.00	0	0	5.00	
6.00	Home Health Aide	58.80	256	277	6.00	
7.00	Total (sum of lines 1-6)		1,192	872	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	Subject to Deductibles & Coinsurance
		5.00	6.00	7.00

Supplies and Drugs Cost Computations

15.00	Cost of Medical Supplies	0.000000	548	354	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	col. 2, line 3.00	2.00
3.00	Speech Pathology	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	col. 2, line 15.00	4.00
5.00	Cost of Drugs	col. 2, line 16.00	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151312

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

Worksheet H-3
Parts I-II
Date/Time Prepared:
1/24/2012 1:07 pm

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Title XVIII

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Cost Center Description	Cost of Services			Total Program Cost (sum of cols. 9-10)	
	Part A	Part B			
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
9.00	10.00	11.00	12.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION					
Cost Per Visit Computation					
1.00	Skilled Nursing Care	56,681	38,538	95,219	1.00
2.00	Physical Therapy	65,776	37,422	103,198	2.00
3.00	Occupational Therapy	0	2,051	2,051	3.00
4.00	Speech Pathology	224	0	224	4.00
5.00	Medical Social Services	0	0	0	5.00
6.00	Home Health Aide	15,053	16,288	31,341	6.00
7.00	Total (sum of lines 1-6)	137,734	94,299	232,033	7.00
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
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: 151312	Period: From 01/01/2011 To 06/30/2011	Worksheet H-4 Part I-II
	HHA CCN: 157514		Date/Time Prepared: 1/24/2012 1:07 pm
	Title XVIII	Home Health Agency I	PPS

	Part A	Part B		
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

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

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	157,099	106,255	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	4,004	0	13.00
14.00	Total PPS Reimbursement - PEP Episodes	717	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	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	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	161,820	106,255	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	161,820	106,255	24.00
25.00	Coinsurance billed to program patients (from your records)	0	0	25.00
26.00	Net cost (line 24 minus line 25)	161,820	106,255	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)	161,820	106,255	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	161,820	106,255	31.00
32.00	Interim payments (see instructions)	161,821	106,255	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)	-1	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: 151312	Period: From 01/01/2011	Worksheet H-5
	HHA CCN: 157514	To 06/30/2011	Date/Time Prepared: 1/24/2012 1:07 pm
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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		161,821		106,255	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)		161,821		106,255	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		1		0	6.02
7.00	Total Medicare program liability (see instructions)		161,820		106,255	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00