

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 Provider CCN: 141319
 SETTLEMENT SUMMARY

Period: From 06/01/2010 To 05/31/2011
 Worksheet 5
 Parts I-III
 Date/Time Prepared: 11/29/2011 9:05 am

PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.
 Date: 11/29/2011 Time: 9:05 am

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HAMMOND-HENRY HOSPITAL for the cost reporting period beginning 06/01/2010 and ending 05/31/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

(signed) Gary S. Gesme
 Officer or Administrator of Provider(s)
Board of Directors Chair
 Title
11-30-11
 Date

Cost Center Description	Title v	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	399,612	-333,189	0	0	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	18,138	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 Skilled Nursing Facility	0	0	0	0	0	7.00
8.00 Nursing Facility	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 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	417,750	-333,189	0	0	200.00

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

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NOV 30 2011

Healthcare & Family Services
 BUREAU OF HEALTH FINANCE

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 141319		Period: From 06/01/2010 To 05/31/2011		Worksheet S-2 Part I Date/Time Prepared: 11/29/2011 8:53 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 600 N. COLLEGE AVENUE			PO Box:						
2.00	City: GENESEO			State: IL		Zip Code: 61254-1099		County: HENRY		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
								6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		HAMMOND-HENRY HOSPITAL	141319	19340	1	06/04/2002	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		HAMMOND-HENRY SWING BED	142319	19340		05/21/2003	N	O	N
8.00	Swing Beds - NF							N		N
9.00	Hospital-Based SNF		HAMMOND-HENRY SKILLED NURSING	145464	19340		06/01/1983	N	P	N
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTG									
12.00	Hospital-Based HHA		HAMMOND-HENRY HOME HEALTH SERVICES	147450	19340		06/05/1986	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC							N	N	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) 1									
17.10	Hospital-Based (CORF) 1									
18.00	Renal Dialysis							N	N	N
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						06/01/2010		05/31/2011	
21.00	Type of Control (see instructions)						11			
Inpatient PPS Information										
22.00	Does this facility qualify for and receive disproportionate share hospital payment in accordance with 42 CFR Section §412.106, or low income payment in accordance with 42 CFR Section §412.624(e)(2)? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						2		N	
				In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.						0	0	0	0
25.00	If this provider is an IRF then enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.						0	0	0	0
							1.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.								2	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.								2	
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	
							Beginning:	Ending:		
							1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.									
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	
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.									

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet S-2
Part I
Date/Time Prepared:
11/29/2011 8:53 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet S-2
Part I
Date/Time Prepared:
11/29/2011 8:53 am

		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
		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	
		4.00	5.00		
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
Long Term Care Hospital PPS					
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.		N		80.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		N		86.00
			V	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	N	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	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.				
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

11/29/2011 8:53 am

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141319	Period: From 06/01/2010 To 05/31/2011	Worksheet S-2 Part I Date/Time Prepared: 11/29/2011 8:53 am	
			V	XIX	
			1.00	2.00	
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N
				1.00	2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.		1,000,000	3,000,000	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
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:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				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

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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.	1.00	N	2.00			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 the 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			
165.00	Multicampus 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
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	Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
							0.00
166.00							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)						0168.00
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

		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	08/09/2011
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			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.		Y	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
Description		Y/N	Date	
0		1.00	2.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/08/2011	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for other? Describe the other adjustments:	N		20.00

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

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	11/08/2011	16.00
17.00	was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	
	Line Number				
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,125	69,768.00	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)		25	9,125	69,768.00	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	43.00				13.00
14.00 Total (see instructions)		25	9,125	69,768.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY	44.00	25	9,125		19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE	46.00	32	11,680		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
25.10 CMHC - CORF	99.10				25.10
26.00 RURAL HEALTH CLINIC	88.00				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00 Total (sum of lines 14-26)		82			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	1,625	468	2,907		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	322	0	366		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,947	468	3,273		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	0		266	384		13.00
14.00 Total (see instructions)	0	1,947	734	3,657		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0	1,127	839	5,001		19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE				9,128		21.00
22.00 HOME HEALTH AGENCY	0	0	0	8,251		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0		25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0		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	620		28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)		0		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: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description	Full Time Equivalents			Discharges		Title XVIII
	Total Interns & Residents	Employees On Payroll	Nonpaid workers	Title V		
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	491	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	216.41	0.00	0	491	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00	11.11	0.00			19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00	17.88	0.00			21.00
22.00 HOME HEALTH AGENCY	0.00	8.58	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	253.98	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

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)	208	1,016	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)	208	1,016	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		32	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
25.10 CMHC - CORF			25.10
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: 141319	Period: From 06/01/2010 To 05/31/2011	Worksheet S-4
	Component CCN: 147450		Date/Time Prepared: 11/29/2011 8:53 am
		Home Health Agency I	PPS

0.00	County	HENRY				1.00	0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	

1.00	HOME HEALTH AGENCY STATISTICAL DATA						
2.00	Home Health Aide Hours	0	2,489	0	0	2,489	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	232.00	0.00	0.00	0.00	2.00

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

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel			1.18	0.00	1.18	5.00
6.00	Direct Nursing Service			5.20	0.00	5.20	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			1.20	0.00	1.20	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00

HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		19340				20.00

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

PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	3,143	38	104	390	3,675	21.00
22.00	Skilled Nursing Visit Charges	392,977	4,533	12,993	49,000	459,503	22.00
23.00	Physical Therapy Visits	1,078	0	6	183	1,267	23.00
24.00	Physical Therapy Visit Charges	171,823	0	950	29,280	202,053	24.00
25.00	Occupational Therapy Visits	373	0	2	56	431	25.00
26.00	Occupational Therapy Visit Charges	59,463	0	320	8,960	68,743	26.00
27.00	Speech Pathology Visits	48	0	0	22	70	27.00
28.00	Speech Pathology Visit Charges	7,680	0	0	3,680	11,360	28.00
29.00	Medical Social Service Visits	48	0	0	1	49	29.00
30.00	Medical Social Service Visit Charges	9,010	0	0	190	9,200	30.00
31.00	Home Health Aide Visits	1,213	0	7	169	1,389	31.00
32.00	Home Health Aide Visit Charges	82,072	0	476	11,492	94,040	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,903	38	119	821	6,881	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)	723,025	4,533	14,739	102,602	844,899	35.00
36.00	Total Number of Episodes (standard/non outlier)	325		44	43	412	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	5,513	19	0	0	5,532	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet S-7

Date/Time Prepared:
11/29/2011 8:53 am

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

	Group	SNF Days	Swing Bed Days	SNF	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00		
3.00	RUX	0	0	0	0	3.00
4.00	RUL	13	0	0	13	4.00
5.00	RVX	14	0	0	14	5.00
6.00	RVL	107	0	0	107	6.00
7.00	RHX	0	0	0	0	7.00
8.00	RHL	0	0	0	0	8.00
9.00	RMX	58	0	0	58	9.00
10.00	RML	67	0	0	67	10.00
11.00	RLX	0	0	0	0	11.00
12.00	RUC	30	0	0	30	12.00
13.00	RUB	13	0	0	13	13.00
14.00	RUA	0	0	0	0	14.00
15.00	RVC	14	0	0	14	15.00
16.00	RVB	57	0	0	57	16.00
17.00	RVA	144	0	0	144	17.00
18.00	RHC	17	0	0	17	18.00
19.00	RHB	126	0	0	126	19.00
20.00	RHA	100	0	0	100	20.00
21.00	RMC	24	0	0	24	21.00
22.00	RMB	34	0	0	34	22.00
23.00	RMA	54	0	0	54	23.00
24.00	RLB	0	0	0	0	24.00
25.00	RLA	0	0	0	0	25.00
26.00	ES3	0	0	0	0	26.00
27.00	ES2	0	0	0	0	27.00
28.00	ES1	43	0	0	43	28.00
29.00	HE2	69	0	0	69	29.00
30.00	HE1	0	0	0	0	30.00
31.00	HD2	0	0	0	0	31.00
32.00	HD1	0	0	0	0	32.00
33.00	HC2	0	0	0	0	33.00
34.00	HC1	8	0	0	8	34.00
35.00	HB2	0	0	0	0	35.00
36.00	HB1	0	0	0	0	36.00
37.00	LE2	0	0	0	0	37.00
38.00	LE1	0	0	0	0	38.00
39.00	LD2	0	0	0	0	39.00
40.00	LD1	6	0	0	6	40.00
41.00	LC2	0	0	0	0	41.00
42.00	LC1	0	0	0	0	42.00
43.00	LB2	0	0	0	0	43.00
44.00	LB1	0	0	0	0	44.00
45.00	CE2	0	0	0	0	45.00
46.00	CE1	0	0	0	0	46.00
47.00	CD2	0	0	0	0	47.00
48.00	CD1	6	0	0	6	48.00
49.00	CC2	6	0	0	6	49.00
50.00	CC1	14	0	0	14	50.00
51.00	CB2	0	0	0	0	51.00
52.00	CB1	42	0	0	42	52.00
53.00	CA2	2	0	0	2	53.00
54.00	CA1	9	0	0	9	54.00
55.00	SE3	0	0	0	0	55.00
56.00	SE2	0	0	0	0	56.00
57.00	SE1	0	0	0	0	57.00
58.00	SSC	0	0	0	0	58.00
59.00	SSB	6	0	0	6	59.00
60.00	SSA	30	0	0	30	60.00
61.00	IB2	0	0	0	0	61.00
62.00	IB1	0	0	0	0	62.00
63.00	IA2	0	0	0	0	63.00
64.00	IA1	0	0	0	0	64.00
65.00	BB2	0	0	0	0	65.00
66.00	BB1	0	0	0	0	66.00
67.00	BA2	0	0	0	0	67.00
68.00	BA1	0	0	0	0	68.00

11/29/2011 8:53 am

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet S-7

Date/Time Prepared:
11/29/2011 8:53 am

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
				1.00	2.00
69.00	PE2	0	0	0	69.00
70.00	PE1	0	0	0	70.00
71.00	PD2	0	0	0	71.00
72.00	PD1	0	0	0	72.00
73.00	PC2	0	0	0	73.00
74.00	PC1	0	0	0	74.00
75.00	PB2	0	0	0	75.00
76.00	PB1	14	0	14	76.00
77.00	PA2	0	0	0	77.00
78.00	PA1	0	0	0	78.00
199.00	AAA	0	0	0	199.00
200.00	TOTAL	1,127	0	1,127	200.00

	CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)

201.00 **SNF SERVICES**
Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).

	Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	403,374	0.97	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	747	0.02	Y	205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (worksheet G-2, Part I, line 7, column 3)	416,152			207.00

1.00	Wage Index Factor	Base Rate			
		Prior to 10/1	Actual Rate for Services Prior to 10/1	Days for Services Prior to 10/1	On/After 10/1

	Group	Base Rate Prior to 10/1	Actual Rate for Services Prior to 10/1	Days for Services Prior to 10/1	Base Rate	
					2.00	3.00
3.00	RUX	195.01	195.01	0	269.98	3.00
4.00	RUL	174.43	174.43	0	263.50	4.00
5.00	RVX	146.09	146.09	0	241.45	5.00
6.00	RVL	137.14	137.14	0	215.54	6.00
7.00	RHX	122.05	122.05	0	219.66	7.00
8.00	RHL	119.37	119.37	0	194.67	8.00
9.00	RMX	136.16	136.16	0	201.49	9.00
10.00	RML	125.88	125.88	0	184.83	10.00
11.00	RLX	96.39	96.39	0	117.63	11.00
12.00	RUC	169.51	169.51	0	201.03	12.00
13.00	RUB	156.99	156.99	0	201.03	13.00
14.00	RUA	150.72	150.72	0	165.39	14.00
15.00	RVC	132.66	132.66	0	172.50	15.00
16.00	RVB	126.85	126.85	0	147.98	16.00
17.00	RVA	116.12	116.12	0	147.51	17.00
18.00	RHC	113.11	113.11	0	150.71	18.00
19.00	RHB	108.63	108.63	0	134.98	19.00
20.00	RHA	101.92	101.92	0	117.85	20.00
21.00	RMC	103.51	103.51	0	133.00	21.00
22.00	RMB	100.82	100.82	0	123.74	22.00
23.00	RMA	99.04	99.04	0	100.60	23.00
24.00	RLB	89.24	89.24	0	129.97	24.00
25.00	RLA	77.16	77.16	0	80.92	25.00
26.00	ES3	195.98	195.98	0	195.98	26.00
27.00	ES2	153.87	153.87	0	153.87	27.00
28.00	ES1	137.67	137.67	0	137.67	28.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet S-7

Date/Time Prepared:
11/29/2011 8:53 am

	Group	Base Rate Prior to 10/1	Actual Rate for Services Prior to 10/1	Days for Services Prior to 10/1	Base Rate On/After 10/1	
	1.00	2.00	3.00	4.00	5.00	
29.00	HE2	133.04	133.04	0	133.04	29.00
30.00	HE1	110.83	110.83	0	110.83	30.00
31.00	HD2	124.71	124.71	0	124.71	31.00
32.00	HD1	104.35	104.35	0	104.35	32.00
33.00	HC2	117.77	117.77	0	117.77	33.00
34.00	HC1	98.80	98.80	0	98.80	34.00
35.00	HB2	116.38	116.38	0	116.38	35.00
36.00	HB1	97.87	97.87	0	97.87	36.00
37.00	LE2	121.01	121.01	0	121.01	37.00
38.00	LE1	101.57	101.57	0	101.57	38.00
39.00	LD2	116.38	116.38	0	116.38	39.00
40.00	LD1	97.87	97.87	0	97.87	40.00
41.00	LC2	102.50	102.50	0	102.50	41.00
42.00	LC1	86.76	86.76	0	86.76	42.00
43.00	LB2	97.41	97.41	0	97.41	43.00
44.00	LB1	83.06	83.06	0	83.06	44.00
45.00	CE2	108.05	108.05	0	108.05	45.00
46.00	CE1	99.72	99.72	0	99.72	46.00
47.00	CD2	102.50	102.50	0	102.50	47.00
48.00	CD1	94.17	94.17	0	94.17	48.00
49.00	CC2	79.84	79.84	0	90.00	49.00
50.00	CC1	73.58	73.58	0	83.53	50.00
51.00	CB2	70.00	70.00	0	83.53	51.00
52.00	CB1	66.87	66.87	0	77.51	52.00
53.00	CA2	66.42	66.42	0	71.03	53.00
54.00	CA1	62.84	62.84	0	66.40	54.00
55.00	SE3	106.23	106.23	0	0.00	55.00
56.00	SE2	91.03	91.03	0	0.00	56.00
57.00	SE1	81.63	81.63	0	0.00	57.00
58.00	SSC	80.29	80.29	0	0.00	58.00
59.00	SSB	76.27	76.27	0	0.00	59.00
60.00	SSA	74.92	74.92	0	0.00	60.00
61.00	IB2	60.16	60.16	0	0.00	61.00
62.00	IB1	59.27	59.27	0	0.00	62.00
63.00	IA2	54.79	54.79	0	0.00	63.00
64.00	IA1	53.00	53.00	0	0.00	64.00
65.00	BB2	59.71	59.71	0	75.20	65.00
66.00	BB1	58.37	58.37	0	71.96	66.00
67.00	BA2	54.35	54.35	0	62.70	67.00
68.00	BA1	50.77	50.77	0	59.93	68.00
69.00	PE2	64.63	64.63	0	99.72	69.00
70.00	PE1	63.74	63.74	0	95.10	70.00
71.00	PD2	61.50	61.50	0	94.17	71.00
72.00	PD1	60.61	60.61	0	89.54	72.00
73.00	PC2	58.82	58.82	0	81.21	73.00
74.00	PC1	58.37	58.37	0	77.51	74.00
75.00	PB2	52.56	52.56	0	69.18	75.00
76.00	PB1	51.66	51.66	0	66.40	76.00
77.00	PA2	51.21	51.21	0	57.61	77.00
78.00	PA1	49.87	49.87	0	55.30	78.00
199.00	AAA	49.87	49.87	0	0.00	199.00
200.00	TOTAL			0		200.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet S-7

Date/Time Prepared:
11/29/2011 8:53 am

	Actual Rate for Services On/After 10/1	Days for Services On/After 10/1	Total	
	6.00	7.00	8.00	
3.00	269.98	0	0	3.00
4.00	263.50	0	0	4.00
5.00	241.45	0	0	5.00
6.00	215.54	0	0	6.00
7.00	219.66	0	0	7.00
8.00	194.67	0	0	8.00
9.00	201.49	0	0	9.00
10.00	184.83	0	0	10.00
11.00	117.63	0	0	11.00
12.00	201.03	0	0	12.00
13.00	201.03	0	0	13.00
14.00	165.39	0	0	14.00
15.00	172.50	0	0	15.00
16.00	147.98	0	0	16.00
17.00	147.51	0	0	17.00
18.00	150.71	0	0	18.00
19.00	134.98	0	0	19.00
20.00	117.85	0	0	20.00
21.00	133.00	0	0	21.00
22.00	123.74	0	0	22.00
23.00	100.60	0	0	23.00
24.00	129.97	0	0	24.00
25.00	80.92	0	0	25.00
26.00	195.98	0	0	26.00
27.00	153.87	0	0	27.00
28.00	137.67	0	0	28.00
29.00	133.04	0	0	29.00
30.00	110.83	0	0	30.00
31.00	124.71	0	0	31.00
32.00	104.35	0	0	32.00
33.00	117.77	0	0	33.00
34.00	98.80	0	0	34.00
35.00	116.38	0	0	35.00
36.00	97.87	0	0	36.00
37.00	121.01	0	0	37.00
38.00	101.57	0	0	38.00
39.00	116.38	0	0	39.00
40.00	97.87	0	0	40.00
41.00	102.50	0	0	41.00
42.00	86.76	0	0	42.00
43.00	97.41	0	0	43.00
44.00	83.06	0	0	44.00
45.00	108.05	0	0	45.00
46.00	99.72	0	0	46.00
47.00	102.50	0	0	47.00
48.00	94.17	0	0	48.00
49.00	90.00	0	0	49.00
50.00	83.53	0	0	50.00
51.00	83.53	0	0	51.00
52.00	77.51	0	0	52.00
53.00	71.03	0	0	53.00
54.00	66.40	0	0	54.00
55.00	0.00	0	0	55.00
56.00	0.00	0	0	56.00
57.00	0.00	0	0	57.00
58.00	0.00	0	0	58.00
59.00	0.00	0	0	59.00
60.00	0.00	0	0	60.00
61.00	0.00	0	0	61.00
62.00	0.00	0	0	62.00
63.00	0.00	0	0	63.00
64.00	0.00	0	0	64.00
65.00	75.20	0	0	65.00
66.00	71.96	0	0	66.00
67.00	62.70	0	0	67.00
68.00	59.93	0	0	68.00
69.00	99.72	0	0	69.00
70.00	95.10	0	0	70.00
71.00	94.17	0	0	71.00
72.00	89.54	0	0	72.00
73.00	81.21	0	0	73.00
74.00	77.51	0	0	74.00
75.00	69.18	0	0	75.00

11/29/2011 8:53 am

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet S-7

Date/Time Prepared:
11/29/2011 8:53 am

	Actual Rate for Services On/After 10/1	Days for Services On/After 10/1	Total	
	6.00	7.00	8.00	
76.00	66.40	0	0	76.00
77.00	57.61	0	0	77.00
78.00	55.30	0	0	78.00
199.00	0.00	0	0	199.00
200.00 TOTAL		0	0	200.00

		1.00	
Uncompensated and indigent care cost computation			
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)	0.506977	1.00
Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid	1,753,554	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	4,824,110	6.00
7.00	Medicaid cost (line 1 times line 6)	2,445,713	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)	692,159	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	117,457	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	692,159	19.00
		Uninsured patients	Insured patients
		1.00	2.00
		Total (col. 1 + col. 2)	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	328,664	22,911
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	166,625	11,615
22.00	Partial payment by patients approved for charity care	0	0
23.00	Cost of charity care (line 21 minus line 22)	166,625	11,615
		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)	869,664	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	44,569	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	825,095	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	418,304	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	596,544	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,288,703	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

worksheet A

Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT		1,029,583	1,029,583	417,164	1,446,747	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		749,879	749,879	16,532	766,411	2.00
4.00	EMPLOYEE BENEFITS	174,634	3,043,741	3,218,375	0	3,218,375	4.00
5.01	DATA PROCESSING	283,205	369,449	652,654	0	652,654	5.01
5.02	PURCHASING RECEIVING AND STORES	108,000	11,038	119,038	0	119,038	5.02
5.03	ADMITTING	140,034	8,498	148,532	0	148,532	5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE	224,802	147,993	372,795	0	372,795	5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	573,462	1,587,541	2,161,003	-100,072	2,060,931	5.05
7.00	OPERATION OF PLANT	184,354	892,775	1,077,129	-83,156	993,973	7.00
8.00	LAUNDRY & LINEN SERVICE	25,466	112,431	137,897	0	137,897	8.00
9.00	HOUSEKEEPING	313,149	85,014	398,163	0	398,163	9.00
10.00	DIETARY	447,580	429,656	877,236	0	877,236	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	120,794	4,604	125,398	0	125,398	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	177,081	696,099	873,180	-516,296	356,884	15.00
16.00	MEDICAL RECORDS & LIBRARY	282,926	63,978	346,904	0	346,904	16.00
17.00	SOCIAL SERVICE	200,139	3,768	203,907	0	203,907	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,727,749	208,117	1,935,866	-44,897	1,890,969	30.00
43.00	NURSERY	147,393	568	147,961	0	147,961	43.00
44.00	SKILLED NURSING FACILITY	403,374	39,028	442,402	0	442,402	44.00
46.00	OTHER LONG TERM CARE	552,147	48,725	600,872	0	600,872	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1,061,034	920,179	1,981,213	0	1,981,213	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	44,897	44,897	52.00
53.00	ANESTHESIOLOGY	609,029	263,019	872,048	0	872,048	53.00
54.00	RADIOLOGY-DIAGNOSTIC	631,855	1,427,013	2,058,868	0	2,058,868	54.00
60.00	LABORATORY	488,449	775,750	1,264,199	0	1,264,199	60.00
66.00	PHYSICAL THERAPY	780,860	108,896	889,756	0	889,756	66.00
67.00	OCCUPATIONAL THERAPY	271,346	15,125	286,471	0	286,471	67.00
68.00	SPEECH PATHOLOGY	63,762	5,222	68,984	0	68,984	68.00
69.00	ELECTROCARDIOLOGY	292,164	196,882	489,046	0	489,046	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	975,906	975,906	0	975,906	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	516,296	516,296	73.00
76.00	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	76.00
76.01	SLEEP LAB	74,461	44,927	119,388	0	119,388	76.01
76.02	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	CLINIC	384,795	387,428	772,223	-350,291	421,932	90.00
91.00	EMERGENCY	452,266	1,347,875	1,800,141	0	1,800,141	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	431,055	105,685	536,740	0	536,740	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	452,877	452,877	-422,208	30,669	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,627,365	16,559,269	28,186,634	-522,031	27,664,603	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	15,559	15,559	192.00
192.02	ORTHO CLINIC	64,838	442,325	507,163	0	507,163	192.02
192.03	LEASED SPACE	0	0	0	119,422	119,422	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	ANESTHESIA BILLING	0	0	0	0	0	194.03
194.04	SPECIALTY CLINIC	3,620	385	4,005	0	4,005	194.04
194.05	COLONA CLINIC	0	0	0	387,050	387,050	194.05
200.00	TOTAL (SUM OF LINES 118-199)	11,695,823	17,001,979	28,697,802	0	28,697,802	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet A

Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-154,880	1,291,867	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	766,411	2.00
4.00	EMPLOYEE BENEFITS	-121,806	3,096,569	4.00
5.01	DATA PROCESSING	0	652,654	5.01
5.02	PURCHASING RECEIVING AND STORES	-605	118,433	5.02
5.03	ADMITTING	0	148,532	5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE	0	372,795	5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	-223,061	1,837,870	5.05
7.00	OPERATION OF PLANT	0	993,973	7.00
8.00	LAUNDRY & LINEN SERVICE	0	137,897	8.00
9.00	HOUSEKEEPING	0	398,163	9.00
10.00	DIETARY	-184,345	692,891	10.00
11.00	CAFETERIA	0	0	11.00
13.00	NURSING ADMINISTRATION	0	125,398	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	PHARMACY	0	356,884	15.00
16.00	MEDICAL RECORDS & LIBRARY	-1,379	345,525	16.00
17.00	SOCIAL SERVICE	0	203,907	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-2,882	1,888,087	30.00
43.00	NURSERY	0	147,961	43.00
44.00	SKILLED NURSING FACILITY	-1,772	440,630	44.00
46.00	OTHER LONG TERM CARE	-1,801	599,071	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	1,981,213	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	44,897	52.00
53.00	ANESTHESIOLOGY	-872,048	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	2,058,868	54.00
60.00	LABORATORY	0	1,264,199	60.00
66.00	PHYSICAL THERAPY	-94,902	794,854	66.00
67.00	OCCUPATIONAL THERAPY	0	286,471	67.00
68.00	SPEECH PATHOLOGY	0	68,984	68.00
69.00	ELECTROCARDIOLOGY	-34,962	454,084	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	975,906	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	516,296	73.00
76.00	DURABLE MEDICAL EQUIPMENT	0	0	76.00
76.01	SLEEP LAB	0	119,388	76.01
76.02	IV THERAPY	0	0	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0	88.00
90.00	CLINIC	-97,207	324,725	90.00
91.00	EMERGENCY	-750,531	1,049,610	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	CORF	0	0	99.10
101.00	HOME HEALTH AGENCY	-4,728	532,012	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	-30,669	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-2,577,578	25,087,025	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	15,559	192.00
192.02	ORTHO CLINIC	0	507,163	192.02
192.03	LEASED SPACE	0	119,422	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	PHYSICIAN BILLING COSTS	0	0	194.01
194.02	KELLY MEDICAL RENTAL AREA	0	0	194.02
194.03	ANESTHESIA BILLING	0	0	194.03
194.04	SPECIALTY CLINIC	0	4,005	194.04
194.05	COLONA CLINIC	0	387,050	194.05
200.00	TOTAL (SUM OF LINES 118-199)	-2,577,578	26,120,224	200.00

	Increases				
	Cost Center 2.00	Line # 3.00	Salary 4.00	Other 5.00	
A - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	516,296	1.00
	TOTALS		0	516,296	
B - CALONA CLINIC BUILDING DEPRECIATION					
1.00	CLINIC	90.00	0	15,316	1.00
2.00	COLONA CLINIC	194.05	0	21,443	2.00
	TOTALS		0	36,759	
C - FMA BUILDING DEPRECIATION					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	15,559	1.00
	TOTALS		0	15,559	
D - APARTMENT RENTAL EXPENSE					
1.00	LEASED SPACE	192.03	0	83,156	1.00
	TOTALS		0	83,156	
E - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	422,208	1.00
	TOTALS		0	422,208	
G - OTHER CAPITAL COSTS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	47,274	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	16,532	2.00
	TOTALS		0	63,806	
H - OFFICE HOUSEKEEPING/MAINT/OTHER					
1.00	LEASED SPACE	192.03	24,118	12,148	1.00
	TOTALS		24,118	12,148	
I - DELIVERY AND LABOR RECLASS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	44,897	0	1.00
	TOTALS		44,897	0	
J - RECLASS SALARIES FOR B-1 EB ALLOC					
1.00	ANESTHESIOLOGY	53.00	0	609,029	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	84,219	2.00
3.00	CLINIC	90.00	0	75,725	3.00
	TOTALS		0	768,973	
K - RECLASS COLONA EXPENSES TO NONREIMB					
1.00	COLONA CLINIC	194.05	190,059	175,548	1.00
	TOTALS		190,059	175,548	
500.00	Grand Total: Increases		259,074	2,094,453	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	wkst. A-7	Ref.	
	6.00	7.00	8.00	9.00	10.00		
A - DRUGS CHARGED TO PATIENTS							
1.00	PHARMACY	15.00	0	516,296		0	1.00
	TOTALS		0	516,296			
B - CALONA CLINIC BUILDING DEPRECIATION							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	36,759		9	1.00
2.00		0.00	0	0		0	2.00
	TOTALS		0	36,759			
C - FMA BUILDING DEPRECIATION							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	15,559		9	1.00
	TOTALS		0	15,559			
D - APARTMENT RENTAL EXPENSE							
1.00	OPERATION OF PLANT	7.00	0	83,156		0	1.00
	TOTALS		0	83,156			
E - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	422,208		9	1.00
	TOTALS		0	422,208			
G - OTHER CAPITAL COSTS							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	63,806		9	1.00
2.00		0.00	0	0		9	2.00
	TOTALS		0	63,806			
H - OFFICE HOUSEKEEPING/MAINT/OTHER							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	24,118	12,148		0	1.00
	TOTALS		24,118	12,148			
I - DELIVERY AND LABOR RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	44,897	0		0	1.00
	TOTALS		44,897	0			
J - RECLASS SALARIES FOR B-1 EB ALLOC							
1.00	ANESTHESIOLOGY	53.00	609,029	0		0	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	84,219	0		0	2.00
3.00	CLINIC	90.00	75,725	0		0	3.00
	TOTALS		768,973	0			
K - RECLASS COLONA EXPENSES TO NONREIMB							
1.00	CLINIC	90.00	190,059	175,548		0	1.00
	TOTALS		190,059	175,548			
500.00	Grand Total: Decreases		1,028,047	1,325,480			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/29/2011 8:53 am

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
	1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,108,543	31,000	0	31,000	0	1.00
2.00	Land Improvements	713,866	0	0	0	0	2.00
3.00	Buildings and Fixtures	24,540,837	13,232,708	0	13,232,708	0	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	9,446,363	3,933,418	0	3,933,418	1,156,925	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,809,609	17,197,126	0	17,197,126	1,156,925	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	35,809,609	17,197,126	0	17,197,126	1,156,925	10.00
SUMMARY OF CAPITAL							
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,029,583	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	749,879	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,779,462	0	0	0	0	3.00
COMPUTATION OF RATIOS							
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	39,626,954	0	39,626,954	0.764264	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	12,222,856	0	12,222,856	0.235736	0	2.00
3.00	Total (sum of lines 1-2)	51,849,810	0	51,849,810	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/29/2011 8:53 am

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,139,543	0		1.00	
2.00	Land Improvements	713,866	0		2.00	
3.00	Buildings and Fixtures	37,773,545	0		3.00	
4.00	Building Improvements	0	0		4.00	
5.00	Fixed Equipment	0	0		5.00	
6.00	Movable Equipment	12,222,856	0		6.00	
7.00	HIT designated Assets	0	0		7.00	
8.00	Subtotal (sum of lines 1-7)	51,849,810	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	51,849,810	0		10.00	
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,029,583		1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	749,879		2.00	
3.00	Total (sum of lines 1-2)	0	1,779,462		3.00	
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,291,867	0
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	766,411	0
3.00	Total (sum of lines 1-2)	0	0	0	2,058,278	0

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,291,867	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	766,411	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,058,278	3.00

		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
1.00	Investment income - buildings and fixtures (chapter 2)	B	-11,118	NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00	Investment income - movable equipment (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00	Investment income - other (chapter 2)		0		0.00 3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,887	OTHER ADMINISTRATIVE AND GENERAL	5.05 7.00
8.00	Television and radio service (chapter 21)		0		0.00 8.00
9.00	Parking lot (chapter 21)		0		0.00 9.00
10.00	Provider-based physician adjustment	A-8-2	-882,700		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00 11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0		12.00
13.00	Laundry and linen service		0		0.00 13.00
14.00	Cafeteria-employees and guests	B	-166,189	DIETARY	10.00 14.00
15.00	Rental of quarters to employee and others		0		0.00 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00	Sale of drugs to other than patients		0		0.00 17.00
18.00	Sale of medical records and abstracts	B	-1,379	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00	Vending machines	B	-3,899	DIETARY	10.00 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00 23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00 24.00
25.00	utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00 25.00
26.00	Depreciation - buildings and fixtures		0	NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00	Depreciation - movable equipment		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00 28.00
29.00	Physicians' assistant		0		0.00 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00 30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00 31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00 32.00
33.00	PHYSICIAN RECRUITMENT EXPENSE	A	-3,743	OTHER ADMINISTRATIVE AND GENERAL	5.05 33.00
33.01	DIETARY RECEIPTS - OTHER	B	-14,257	DIETARY	10.00 33.01
33.02			0		0.00 33.02
33.03			0		0.00 33.03
33.05	CRNA FRINGES	A	-121,806	EMPLOYEE BENEFITS	4.00 33.05
33.08	ADVERTISING EXPENSE	A	-86,156	OTHER ADMINISTRATIVE AND GENERAL	5.05 33.08
33.09	NURSE ANESTHESIA EXPENSE	A	-872,048	ANESTHESIOLOGY	53.00 33.09
33.11	SUPPLIES REBATES	B	-109	OTHER ADMINISTRATIVE AND GENERAL	5.05 33.11
33.13	FOUNDATION EXPENSES	A	-98,678	OTHER ADMINISTRATIVE AND GENERAL	5.05 33.13
33.16	ATHLETIC TRAINING REVENUE	B	-18,153	PHYSICAL THERAPY	66.00 33.16
34.00	MEDICAID BED TAX	A	-30,488	OTHER ADMINISTRATIVE AND GENERAL	5.05 34.00
35.00	LIFELINE REVENUE	B	-4,728	HOME HEALTH AGENCY	101.00 35.00
36.00	A/P REVENUE	B	-605	PURCHASING RECEIVING AND STORES	5.02 36.00
37.00	PHYSICAL THERAPY TO SUMMIT	B	-63,030	PHYSICAL THERAPY	66.00 37.00
38.00	UNNECESSARY BORROWING	A	-143,762	NEW CAP REL COSTS-BLDG & FIXT	1.00 38.00
40.00	CABLE TV	A	-2,882	ADULTS & PEDIATRICS	30.00 40.00
41.00	CABLE TV	A	-1,772	SKILLED NURSING FACILITY	44.00 41.00

Provider CCN: 141319

Period:
 From 06/01/2010
 To 05/31/2011

Worksheet A-8

Date/Time Prepared:
 11/29/2011 8:53 am

Expense Classification on worksheet A
 To/From which the Amount is to be Adjusted

		Basis/Code (2)	Amount	Cost Center	Line #	
42.00	CABLE TV	1.00	2.00	3.00	4.00	
43.00	PT OUTREACH REVENUE	A	-1,801	OTHER LONG TERM CARE	46.00	42.00
44.00	UNNECESSARY BORROWING - CAP LEASE	B	-13,719	PHYSICAL THERAPY	66.00	43.00
45.00		A	-30,669	INTEREST EXPENSE	113.00	44.00
45.00			0		0.00	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-2,577,578			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

worksheet A-8

Date/Time Prepared:
11/29/2011 8:53 am

		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - buildings and fixtures (chapter 2)	9	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 EXPENSE	0	33.00
33.01	DIETARY RECEIPTS - OTHER	0	33.01
33.02		0	33.02
33.03		0	33.03
33.05	CRNA FRINGES	0	33.05
33.08	ADVERTISING EXPENSE	0	33.08
33.09	NURSE ANESTHESIA EXPENSE	0	33.09
33.11	SUPPLIES REBATES	0	33.11
33.13	FOUNDATION EXPENSES	0	33.13
33.16	ATHLETIC TRAINING REVENUE	0	33.16
34.00	MEDICAID BED TAX	0	34.00
35.00	LIFELINE REVENUE	0	35.00
36.00	A/P REVENUE	0	36.00
37.00	PHYSICAL THERAPY TO SUMMIT	0	37.00
38.00	UNNECESSARY BORROWING	9	38.00
40.00	CABLE TV	0	40.00
41.00	CABLE TV	0	41.00
42.00	CABLE TV	0	42.00
43.00	PT OUTREACH REVENUE	0	43.00
44.00	UNNECESSARY BORROWING - CAP LEASE	0	44.00
45.00		0	45.00
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: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet A-8-2

Date/Time Prepared:
11/29/2011 8:53 am

	wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	60.00	LABORATORY	55,400	0	1.00
2.00	91.00	EMERGENCY	1,237,938	750,531	2.00
3.00	69.00	EKG	34,962	34,962	3.00
4.00	90.00	COLONA CLINIC PHYSICIAN SALARIES	76,639	76,639	4.00
5.00	90.00	COLONA CLINIC PHYSICIAN EMPLOYEE BEN	14,292	14,292	5.00
6.00	90.00	PAIN MANAGEMENT CLINIC	3,750	3,750	6.00
7.00	90.00	WOUND CLINIC	2,526	2,526	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00		TOTAL (lines 1.00 through 199.00)	1,425,507	882,700	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet A-8-2

Date/Time Prepared:
11/29/2011 8:53 am

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	55,400	0	0	0	0	1.00
2.00	487,407	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	542,807		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet A-8-2

Date/Time Prepared:

11/29/2011 8:53 am

	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: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet A-8-2

Date/Time Prepared:
11/29/2011 8:53 am

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	0	1.00
2.00	0	750,531	2.00
3.00	0	34,962	3.00
4.00	0	76,639	4.00
5.00	0	14,292	5.00
6.00	0	3,750	6.00
7.00	0	2,526	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	882,700	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet B
Part I
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	DATA PROCESSING	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,291,867	1,291,867			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	766,411		766,411		2.00
4.00	EMPLOYEE BENEFITS	3,096,569	2,627	75	3,099,271	4.00
5.01	DATA PROCESSING	652,654	12,050	154,018	81,632	900,354 5.01
5.02	PURCHASING RECEIVING AND STORES	118,433	27,779	109	31,130	1,304 5.02
5.03	ADMITTING	148,532	6,795	2,493	40,364	0 5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE	372,795	17,124	2,160	64,798	18,694 5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	1,837,870	126,554	36,998	134,070	61,734 5.05
7.00	OPERATION OF PLANT	993,973	128,446	41,245	53,139	0 7.00
8.00	LAUNDRY & LINEN SERVICE	137,897	9,260	113	7,340	0 8.00
9.00	HOUSEKEEPING	398,163	7,334	3,099	90,264	0 9.00
10.00	DIETARY	692,891	49,345	12,887	129,013	2,174 10.00
11.00	CAFETERIA	0	0	0	0	0 11.00
13.00	NURSING ADMINISTRATION	125,398	1,241	284	34,818	40,431 13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00	PHARMACY	356,884	11,844	3,294	51,043	32,171 15.00
16.00	MEDICAL RECORDS & LIBRARY	345,525	24,809	9,270	81,552	60,429 16.00
17.00	SOCIAL SERVICE	203,907	2,978	0	57,689	3,043 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,888,087	124,885	48,767	485,074	69,994 30.00
43.00	NURSERY	147,961	0	6,430	42,485	0 43.00
44.00	SKILLED NURSING FACILITY	440,630	89,310	3,691	116,271	27,824 44.00
46.00	OTHER LONG TERM CARE	599,071	111,364	6,104	159,154	10,434 46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,981,213	115,917	145,060	305,838	40,866 50.00
52.00	DELIVERY ROOM & LABOR ROOM	44,897	4,835	0	12,941	0 52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,058,868	60,830	66,919	182,129	39,127 54.00
60.00	LABORATORY	1,264,199	13,530	19,318	140,793	24,346 60.00
66.00	PHYSICAL THERAPY	794,854	27,847	28,086	225,079	40,866 66.00
67.00	OCCUPATIONAL THERAPY	286,471	19,871	1,118	78,214	35,214 67.00
68.00	SPEECH PATHOLOGY	68,984	6,607	567	18,379	0 68.00
69.00	ELECTROCARDIOLOGY	454,084	13,256	65,400	84,215	23,476 69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	975,906	0	0	0	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	516,296	0	0	0	0 73.00
76.00	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0 76.00
76.01	SLEEP LAB	119,388	4,519	2,701	21,463	0 76.01
76.02	IV THERAPY	0	0	0	0	0 76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
90.00	CLINIC	324,725	0	53,974	34,304	92,061 90.00
91.00	EMERGENCY	1,049,610	29,028	38,173	130,363	175,636 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0	0	0 99.10
101.00	HOME HEALTH AGENCY	532,012	10,697	4,514	124,249	94,774 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0 113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	25,087,025	1,060,682	756,867	3,017,803	894,598 118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,558	0	0	0 190.00
192.00	PHYSICIANS' PRIVATE OFFICES	15,559	39,709	2,431	0	0 192.00
192.02	ORTHO CLINIC	507,163	2,704	7,113	18,689	0 192.02
192.03	LEASED SPACE	119,422	149,901	0	6,952	0 192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	25,426	0	0	0 194.00
194.01	PHYSICIAN BILLING COSTS	0	0	0	0	0 194.01
194.02	KELLY MEDICAL RENTAL AREA	0	4,887	0	0	0 194.02
194.03	ANESTHESIA BILLING	0	0	0	0	0 194.03
194.04	SPECIALTY CLINIC	4,005	0	0	1,043	0 194.04
194.05	COLONA CLINIC	387,050	0	0	54,784	5,756 194.05
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)	26,120,224	1,291,867	766,411	3,099,271	900,354 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet B
Part I
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
	5.02	5.03	5.04	5A.04	5.05	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 DATA PROCESSING						5.01
5.02 PURCHASING RECEIVING AND STORES	178,755					5.02
5.03 ADMITTING	334	198,518				5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE	476	0	476,047			5.04
5.05 OTHER ADMINISTRATIVE AND GENERAL	6,063	0	0	2,203,289	2,203,289	5.05
7.00 OPERATION OF PLANT	3,544	0	0	1,220,347	112,422	7.00
8.00 LAUNDRY & LINEN SERVICE	186	0	0	154,796	14,260	8.00
9.00 HOUSEKEEPING	3,148	0	0	502,008	46,246	9.00
10.00 DIETARY	2,338	0	0	888,648	81,865	10.00
11.00 CAFETERIA	0	0	0	0	0	11.00
13.00 NURSING ADMINISTRATION	6	0	0	202,178	18,625	13.00
14.00 CENTRAL SERVICES & SUPPLY	1,499	0	0	1,499	138	14.00
15.00 PHARMACY	552	0	0	455,788	41,989	15.00
16.00 MEDICAL RECORDS & LIBRARY	380	0	0	521,965	48,085	16.00
17.00 SOCIAL SERVICE	16	0	0	267,633	24,655	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	8,217	10,824	24,646	2,660,494	245,093	30.00
43.00 NURSERY	32	1,113	2,535	200,556	18,476	43.00
44.00 SKILLED NURSING FACILITY	1,511	1,578	3,592	684,407	63,050	44.00
46.00 OTHER LONG TERM CARE	1,874	6,302	14,349	908,652	83,708	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	42,137	38,667	88,044	2,757,742	254,042	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	1,462	3,329	67,464	6,215	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	13,617	41,864	95,342	2,558,696	235,715	54.00
60.00 LABORATORY	19,723	21,725	49,467	1,553,101	143,076	60.00
66.00 PHYSICAL THERAPY	1,295	11,673	26,580	1,156,280	106,520	66.00
67.00 OCCUPATIONAL THERAPY	125	3,923	8,933	433,869	39,969	67.00
68.00 SPEECH PATHOLOGY	51	563	1,281	96,432	8,884	68.00
69.00 ELECTROCARDIOLOGY	1,175	10,405	22,587	674,598	62,146	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,330	3,029	4,359	402	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	55,487	5,341	12,160	1,048,894	96,627	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	15,590	35,498	567,384	52,269	73.00
76.00 DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	76.00
76.01 SLEEP LAB	273	2,549	5,805	156,698	14,435	76.01
76.02 IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 CLINIC	1,802	0	5,377	512,243	47,189	90.00
91.00 EMERGENCY	5,451	18,611	24,800	1,471,672	135,575	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	1,717	0	6,509	774,472	71,347	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	173,029	193,520	433,863	24,706,164	2,073,023	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	8,558	788	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	57,699	5,315	192.00
192.02 ORTHO CLINIC	0	0	0	535,669	49,347	192.02
192.03 LEASED SPACE	0	0	0	276,275	25,451	192.03
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	25,426	2,342	194.00
194.01 PHYSICIAN BILLING COSTS	0	0	27,484	27,484	2,532	194.01
194.02 KELLY MEDICAL RENTAL AREA	0	0	0	4,887	450	194.02
194.03 ANESTHESIA BILLING	3,787	4,998	11,380	20,165	1,858	194.03
194.04 SPECIALTY CLINIC	7	0	0	5,055	466	194.04
194.05 COLONA CLINIC	1,932	0	3,320	452,842	41,717	194.05
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)	178,755	198,518	476,047	26,120,224	2,203,289	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet B
Part I
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	DATA PROCESSING						5.01
5.02	PURCHASING RECEIVING AND STORES						5.02
5.03	ADMITTING						5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	OPERATION OF PLANT	1,332,769					7.00
8.00	LAUNDRY & LINEN SERVICE	15,089	184,145				8.00
9.00	HOUSEKEEPING	11,951	15,037	575,242			9.00
10.00	DIETARY	80,409	1,121	10,947	1,062,990		10.00
11.00	CAFETERIA	0	0	20,723	714,101	734,824	11.00
13.00	NURSING ADMINISTRATION	2,022	0	0	0	4,737	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	19,300	0	7,108	0	13,262	15.00
16.00	MEDICAL RECORDS & LIBRARY	40,428	0	5,098	0	43,102	16.00
17.00	SOCIAL SERVICE	4,853	0	1,787	0	17,951	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	203,504	36,851	153,808	73,587	151,805	30.00
43.00	NURSERY	0	0	4,229	0	853	43.00
44.00	SKILLED NURSING FACILITY	145,533	22,096	79,715	94,395	52,623	44.00
46.00	OTHER LONG TERM CARE	181,471	50,859	67,329	180,907	84,689	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	188,889	23,099	87,782	0	83,268	50.00
52.00	DELIVERY ROOM & LABOR ROOM	7,879	0	630	0	5,305	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	99,123	10,647	9,477	0	53,096	54.00
60.00	LABORATORY	22,048	0	7,738	0	52,339	60.00
66.00	PHYSICAL THERAPY	45,378	10,448	7,336	0	72,469	66.00
67.00	OCCUPATIONAL THERAPY	32,381	0	3,209	0	19,657	67.00
68.00	SPEECH PATHOLOGY	10,766	0	0	0	4,737	68.00
69.00	ELECTROCARDIOLOGY	21,601	0	6,928	0	21,504	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES 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	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	76.00
76.01	SLEEP LAB	7,363	1,249	0	0	7,057	76.01
76.02	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	CLINIC	0	0	15,595	0	0	90.00
91.00	EMERGENCY	47,303	11,076	25,432	0	37,797	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	17,432	0	3,989	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,204,723	182,483	518,860	1,062,990	726,251	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,945	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	64,706	0	0	0	0	192.00
192.02	ORTHO CLINIC	0	0	0	0	8,573	192.02
192.03	LEASED SPACE	0	1,662	34,549	0	0	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	41,432	0	0	0	0	194.00
194.01	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	KELLY MEDICAL RENTAL AREA	7,963	0	0	0	0	194.02
194.03	ANESTHESIA BILLING	0	0	0	0	0	194.03
194.04	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	COLONA CLINIC	0	0	21,833	0	0	194.05
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)	1,332,769	184,145	575,242	1,062,990	734,824	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet B
Part I
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description	NURSING	CENTRAL	PHARMACY	MEDICAL	SOCIAL SERVICE	
	ADMINISTRATION	SERVICES & SUPPLY		RECORDS & LIBRARY		
	13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 DATA PROCESSING						5.01
5.02 PURCHASING RECEIVING AND STORES						5.02
5.03 ADMITTING						5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA						11.00
13.00 NURSING ADMINISTRATION	227,562					13.00
14.00 CENTRAL SERVICES & SUPPLY	0	1,637				14.00
15.00 PHARMACY	0	0	537,447			15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	658,678		16.00
17.00 SOCIAL SERVICE	7,083	0	0	0	323,962	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	59,895	0	0	34,103	127,827	30.00
43.00 NURSERY	336	0	0	3,508	0	43.00
44.00 SKILLED NURSING FACILITY	20,762	0	0	4,971	100,864	44.00
46.00 OTHER LONG TERM CARE	29,938	0	0	19,854	57,922	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	32,853	0	0	121,826	1,398	50.00
52.00 DELIVERY ROOM & LABOR ROOM	2,093	0	0	4,607	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	20,800	0	0	131,899	0	54.00
60.00 LABORATORY	20,071	0	0	68,447	0	60.00
66.00 PHYSICAL THERAPY	0	0	0	36,779	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	12,360	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	1,773	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	31,253	599	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,637	0	4,191	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	16,826	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	537,447	49,118	0	73.00
76.00 DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	76.00
76.01 SLEEP LAB	2,784	0	0	8,032	0	76.01
76.02 IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 CLINIC	0	0	0	7,440	15,579	90.00
91.00 EMERGENCY	14,913	0	0	34,315	11,484	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	16,034	0	0	9,007	8,289	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	227,562	1,637	537,447	600,309	323,962	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02 ORTHO CLINIC	0	0	0	0	0	192.02
192.03 LEASED SPACE	0	0	0	0	0	192.03
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 PHYSICIAN BILLING COSTS	0	0	0	38,029	0	194.01
194.02 KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03 ANESTHESIA BILLING	0	0	0	15,746	0	194.03
194.04 SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05 COLONA CLINIC	0	0	0	4,594	0	194.05
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)	227,562	1,637	537,447	658,678	323,962	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet B
Part I
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
GENERAL SERVICE COST CENTERS	24.00	25.00	26.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 EMPLOYEE BENEFITS				4.00
5.01 DATA PROCESSING				5.01
5.02 PURCHASING RECEIVING AND STORES				5.02
5.03 ADMITTING				5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE				5.04
5.05 OTHER ADMINISTRATIVE AND GENERAL				5.05
7.00 OPERATION OF PLANT				7.00
8.00 LAUNDRY & LINEN SERVICE				8.00
9.00 HOUSEKEEPING				9.00
10.00 DIETARY				10.00
11.00 CAFETERIA				11.00
13.00 NURSING ADMINISTRATION				13.00
14.00 CENTRAL SERVICES & SUPPLY				14.00
15.00 PHARMACY				15.00
16.00 MEDICAL RECORDS & LIBRARY				16.00
17.00 SOCIAL SERVICE				17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	3,746,967	0	3,746,967	30.00
43.00 NURSERY	227,958	0	227,958	43.00
44.00 SKILLED NURSING FACILITY	1,268,416	0	1,268,416	44.00
46.00 OTHER LONG TERM CARE	1,665,329	0	1,665,329	46.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	3,550,899	0	3,550,899	50.00
52.00 DELIVERY ROOM & LABOR ROOM	94,193	0	94,193	52.00
53.00 ANESTHESIOLOGY	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	3,119,453	0	3,119,453	54.00
60.00 LABORATORY	1,866,820	0	1,866,820	60.00
66.00 PHYSICAL THERAPY	1,435,210	0	1,435,210	66.00
67.00 OCCUPATIONAL THERAPY	541,445	0	541,445	67.00
68.00 SPEECH PATHOLOGY	122,592	0	122,592	68.00
69.00 ELECTROCARDIOLOGY	818,629	0	818,629	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	10,589	0	10,589	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,162,347	0	1,162,347	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,206,218	0	1,206,218	73.00
76.00 DURABLE MEDICAL EQUIPMENT	0	0	0	76.00
76.01 SLEEP LAB	197,618	0	197,618	76.01
76.02 IV THERAPY	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
90.00 CLINIC	598,046	0	598,046	90.00
91.00 EMERGENCY	1,789,567	0	1,789,567	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
99.10 CORF	0	0	0	99.10
101.00 HOME HEALTH AGENCY	900,570	0	900,570	101.00
SPECIAL PURPOSE COST CENTERS				
113.00 INTEREST EXPENSE	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	24,322,866	0	24,322,866	118.00
NONREIMBURSABLE COST CENTERS				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,291	0	23,291	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	127,720	0	127,720	192.00
192.02 ORTHO CLINIC	593,589	0	593,589	192.02
192.03 LEASED SPACE	337,937	0	337,937	192.03
194.00 OTHER NONREIMBURSABLE COST CENTERS	69,200	0	69,200	194.00
194.01 PHYSICIAN BILLING COSTS	68,045	0	68,045	194.01
194.02 KELLY MEDICAL RENTAL AREA	13,300	0	13,300	194.02
194.03 ANESTHESIA BILLING	37,769	0	37,769	194.03
194.04 SPECIALTY CLINIC	5,521	0	5,521	194.04
194.05 COLONA CLINIC	520,986	0	520,986	194.05
200.00 Cross Foot Adjustments	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	26,120,224	0	26,120,224	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet B
Part II
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	2,627	75	2,702	4.00
5.01	DATA PROCESSING	0	12,050	154,018	166,068	5.01
5.02	PURCHASING RECEIVING AND STORES	0	27,779	109	27,888	5.02
5.03	ADMITTING	0	6,795	2,493	9,288	5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE	0	17,124	2,160	19,284	5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	0	126,554	36,998	163,552	5.05
7.00	OPERATION OF PLANT	0	128,446	41,245	169,691	7.00
8.00	LAUNDRY & LINEN SERVICE	0	9,260	113	9,373	8.00
9.00	HOUSEKEEPING	0	7,334	3,099	10,433	9.00
10.00	DIETARY	0	49,345	12,887	62,232	10.00
11.00	CAFETERIA	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	0	1,241	284	1,525	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	PHARMACY	0	11,844	3,294	15,138	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	24,809	9,270	34,079	16.00
17.00	SOCIAL SERVICE	0	2,978	0	2,978	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	124,885	48,767	173,652	30.00
43.00	NURSERY	0	0	6,430	6,430	43.00
44.00	SKILLED NURSING FACILITY	0	89,310	3,691	93,001	44.00
46.00	OTHER LONG TERM CARE	0	111,364	6,104	117,468	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	115,917	145,060	260,977	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	4,835	0	4,835	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	60,830	66,919	127,749	54.00
60.00	LABORATORY	0	13,530	19,318	32,848	60.00
66.00	PHYSICAL THERAPY	0	27,847	28,086	55,933	66.00
67.00	OCCUPATIONAL THERAPY	0	19,871	1,118	20,989	67.00
68.00	SPEECH PATHOLOGY	0	6,607	567	7,174	68.00
69.00	ELECTROCARDIOLOGY	0	13,256	65,400	78,656	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	DURABLE MEDICAL EQUIPMENT	0	0	0	0	76.00
76.01	SLEEP LAB	0	4,519	2,701	7,220	76.01
76.02	IV THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	CLINIC	0	0	53,974	53,974	90.00
91.00	EMERGENCY	0	29,028	38,173	67,201	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	10,697	4,514	15,211	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,060,682	756,867	1,817,549	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,558	0	8,558	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	39,709	2,431	42,140	192.00
192.02	ORTHO CLINIC	0	2,704	7,113	9,817	192.02
192.03	LEASED SPACE	0	149,901	0	149,901	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	25,426	0	25,426	194.00
194.01	PHYSICIAN BILLING COSTS	0	0	0	0	194.01
194.02	KELLY MEDICAL RENTAL AREA	0	4,887	0	4,887	194.02
194.03	ANESTHESIA BILLING	0	0	0	0	194.03
194.04	SPECIALTY CLINIC	0	0	0	0	194.04
194.05	COLONA CLINIC	0	0	0	0	194.05
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,291,867	766,411	2,058,278	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet B
Part II
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description		DATA	PURCHASING	ADMITTING	CASHIERING/ACC	OTHER	
		PROCESSING	RECEIVING AND STORES		OUNTS RECEIVABLE	ADMINISTRATIVE AND GENERAL	
		5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	DATA PROCESSING	166,139					5.01
5.02	PURCHASING RECEIVING AND STORES	241	28,156				5.02
5.03	ADMITTING	0	53	9,376			5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE	3,450	75	0	22,865		5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	11,391	955	0	0	176,015	5.05
7.00	OPERATION OF PLANT	0	558	0	0	8,981	7.00
8.00	LAUNDRY & LINEN SERVICE	0	29	0	0	1,139	8.00
9.00	HOUSEKEEPING	0	496	0	0	3,694	9.00
10.00	DIETARY	401	368	0	0	6,540	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	7,461	1	0	0	1,488	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	236	0	0	11	14.00
15.00	PHARMACY	5,936	87	0	0	3,354	15.00
16.00	MEDICAL RECORDS & LIBRARY	11,151	60	0	0	3,841	16.00
17.00	SOCIAL SERVICE	562	3	0	0	1,970	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	12,916	1,294	511	1,185	19,579	30.00
43.00	NURSERY	0	5	53	122	1,476	43.00
44.00	SKILLED NURSING FACILITY	5,134	238	74	173	5,037	44.00
46.00	OTHER LONG TERM CARE	1,925	295	298	690	6,687	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	7,541	6,637	1,826	4,233	20,305	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	69	160	496	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	7,220	2,145	1,979	4,560	18,829	54.00
60.00	LABORATORY	4,492	3,107	1,026	2,378	11,429	60.00
66.00	PHYSICAL THERAPY	7,541	204	551	1,278	8,509	66.00
67.00	OCCUPATIONAL THERAPY	6,498	20	185	429	3,193	67.00
68.00	SPEECH PATHOLOGY	0	8	27	62	710	68.00
69.00	ELECTROCARDIOLOGY	4,332	185	491	1,086	4,964	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	63	146	32	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	8,740	252	585	7,719	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	736	1,707	4,175	73.00
76.00	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	76.00
76.01	SLEEP LAB	0	43	120	279	1,153	76.01
76.02	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	CLINIC	16,988	284	0	259	3,770	90.00
91.00	EMERGENCY	32,409	859	879	1,192	10,830	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	17,488	270	0	313	5,699	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	165,077	27,255	9,140	20,837	165,610	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	63	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	425	192.00
192.02	ORTHO CLINIC	0	0	0	0	3,942	192.02
192.03	LEASED SPACE	0	0	0	0	2,033	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	187	194.00
194.01	PHYSICIAN BILLING COSTS	0	0	0	1,321	202	194.01
194.02	KELLY MEDICAL RENTAL AREA	0	0	0	0	36	194.02
194.03	ANESTHESIA BILLING	0	596	236	547	148	194.03
194.04	SPECIALTY CLINIC	0	1	0	0	37	194.04
194.05	COLONA CLINIC	1,062	304	0	160	3,332	194.05
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)	166,139	28,156	9,376	22,865	176,015	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet B
Part II
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.01	DATA PROCESSING					5.01
5.02	PURCHASING RECEIVING AND STORES					5.02
5.03	ADMITTING					5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL					5.05
7.00	OPERATION OF PLANT	179,276				7.00
8.00	LAUNDRY & LINEN SERVICE	2,030	12,577			8.00
9.00	HOUSEKEEPING	1,608	1,027	17,337		9.00
10.00	DIETARY	10,816	77	330	80,876	10.00
11.00	CAFETERIA	0	0	625	54,331	54,956
13.00	NURSING ADMINISTRATION	272	0	0	0	354
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	PHARMACY	2,596	0	214	0	992
16.00	MEDICAL RECORDS & LIBRARY	5,438	0	154	0	3,224
17.00	SOCIAL SERVICE	653	0	54	0	1,343
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	27,374	2,517	4,636	5,599	11,352
43.00	NURSERY	0	0	127	0	64
44.00	SKILLED NURSING FACILITY	19,576	1,509	2,402	7,182	3,936
46.00	OTHER LONG TERM CARE	24,410	3,473	2,029	13,764	6,334
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	25,408	1,578	2,646	0	6,227
52.00	DELIVERY ROOM & LABOR ROOM	1,060	0	19	0	397
53.00	ANESTHESIOLOGY	0	0	0	0	0
54.00	RADIOLOGY-DIAGNOSTIC	13,333	727	286	0	3,971
60.00	LABORATORY	2,966	0	233	0	3,914
66.00	PHYSICAL THERAPY	6,104	714	221	0	5,420
67.00	OCCUPATIONAL THERAPY	4,356	0	97	0	1,470
68.00	SPEECH PATHOLOGY	1,448	0	0	0	354
69.00	ELECTROCARDIOLOGY	2,906	0	209	0	1,608
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0
76.01	SLEEP LAB	990	85	0	0	528
76.02	IV THERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0
90.00	CLINIC	0	0	470	0	0
91.00	EMERGENCY	6,363	756	766	0	2,827
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0	0	0
101.00	HOME HEALTH AGENCY	2,345	0	120	0	0
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	162,052	12,463	15,638	80,876	54,315
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,876	0	0	0	0
192.00	PHYSICIANS' PRIVATE OFFICES	8,704	0	0	0	0
192.02	ORTHO CLINIC	0	0	0	0	641
192.03	LEASED SPACE	0	114	1,041	0	0
194.00	OTHER NONREIMBURSABLE COST CENTERS	5,573	0	0	0	0
194.01	PHYSICIAN BILLING COSTS	0	0	0	0	0
194.02	KELLY MEDICAL RENTAL AREA	1,071	0	0	0	0
194.03	ANESTHESIA BILLING	0	0	0	0	0
194.04	SPECIALTY CLINIC	0	0	0	0	0
194.05	COLONA CLINIC	0	0	658	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	179,276	12,577	17,337	80,876	54,956

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet B
Part II
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description	NURSING	CENTRAL	PHARMACY	MEDICAL	SOCIAL SERVICE	
	ADMINISTRATION	SERVICES & SUPPLY		RECORDS & LIBRARY		
	13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 DATA PROCESSING						5.01
5.02 PURCHASING RECEIVING AND STORES						5.02
5.03 ADMITTING						5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA						11.00
13.00 NURSING ADMINISTRATION	11,131					13.00
14.00 CENTRAL SERVICES & SUPPLY	0	247				14.00
15.00 PHARMACY	0	0	28,361			15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	58,018		16.00
17.00 SOCIAL SERVICE	346	0	0	0	7,959	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,932	0	0	3,004	3,140	30.00
43.00 NURSERY	16	0	0	309	0	43.00
44.00 SKILLED NURSING FACILITY	1,016	0	0	438	2,478	44.00
46.00 OTHER LONG TERM CARE	1,464	0	0	1,749	1,423	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,607	0	0	10,730	34	50.00
52.00 DELIVERY ROOM & LABOR ROOM	102	0	0	406	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,017	0	0	11,620	0	54.00
60.00 LABORATORY	982	0	0	6,029	0	60.00
66.00 PHYSICAL THERAPY	0	0	0	3,239	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	1,089	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	156	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	2,753	15	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	247	0	369	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	1,482	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	28,361	4,326	0	73.00
76.00 DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	76.00
76.01 SLEEP LAB	136	0	0	707	0	76.01
76.02 IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 CLINIC	0	0	0	655	383	90.00
91.00 EMERGENCY	729	0	0	3,022	282	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	784	0	0	793	204	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	11,131	247	28,361	52,876	7,959	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02 ORTHO CLINIC	0	0	0	0	0	192.02
192.03 LEASED SPACE	0	0	0	0	0	192.03
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 PHYSICIAN BILLING COSTS	0	0	0	3,350	0	194.01
194.02 KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03 ANESTHESIA BILLING	0	0	0	1,387	0	194.03
194.04 SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05 COLONA CLINIC	0	0	0	405	0	194.05
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)	11,131	247	28,361	58,018	7,959	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet B
Part II
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	EMPLOYEE BENEFITS				4.00
5.01	DATA PROCESSING				5.01
5.02	PURCHASING RECEIVING AND STORES				5.02
5.03	ADMITTING				5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE				5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL				5.05
7.00	OPERATION OF PLANT				7.00
8.00	LAUNDRY & LINEN SERVICE				8.00
9.00	HOUSEKEEPING				9.00
10.00	DIETARY				10.00
11.00	CAFETERIA				11.00
13.00	NURSING ADMINISTRATION				13.00
14.00	CENTRAL SERVICES & SUPPLY				14.00
15.00	PHARMACY				15.00
16.00	MEDICAL RECORDS & LIBRARY				16.00
17.00	SOCIAL SERVICE				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	270,118	0	270,118	30.00
43.00	NURSERY	8,639	0	8,639	43.00
44.00	SKILLED NURSING FACILITY	142,295	0	142,295	44.00
46.00	OTHER LONG TERM CARE	182,148	0	182,148	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	350,015	0	350,015	50.00
52.00	DELIVERY ROOM & LABOR ROOM	7,555	0	7,555	52.00
53.00	ANESTHESIOLOGY	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	193,595	0	193,595	54.00
60.00	LABORATORY	69,527	0	69,527	60.00
66.00	PHYSICAL THERAPY	89,910	0	89,910	66.00
67.00	OCCUPATIONAL THERAPY	38,394	0	38,394	67.00
68.00	SPEECH PATHOLOGY	9,955	0	9,955	68.00
69.00	ELECTROCARDIOLOGY	97,278	0	97,278	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	857	0	857	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	18,778	0	18,778	72.00
73.00	DRUGS CHARGED TO PATIENTS	39,305	0	39,305	73.00
76.00	DURABLE MEDICAL EQUIPMENT	0	0	0	76.00
76.01	SLEEP LAB	11,280	0	11,280	76.01
76.02	IV THERAPY	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0	88.00
90.00	CLINIC	76,813	0	76,813	90.00
91.00	EMERGENCY	128,229	0	128,229	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	CORF	0	0	0	99.10
101.00	HOME HEALTH AGENCY	43,335	0	43,335	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,778,026	0	1,778,026	118.00
NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,497	0	10,497	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	51,269	0	51,269	192.00
192.02	ORTHO CLINIC	14,416	0	14,416	192.02
192.03	LEASED SPACE	153,095	0	153,095	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	31,186	0	31,186	194.00
194.01	PHYSICIAN BILLING COSTS	4,873	0	4,873	194.01
194.02	KELLY MEDICAL RENTAL AREA	5,994	0	5,994	194.02
194.03	ANESTHESIA BILLING	2,914	0	2,914	194.03
194.04	SPECIALTY CLINIC	39	0	39	194.04
194.05	COLONA CLINIC	5,969	0	5,969	194.05
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,058,278	0	2,058,278	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet B
Part II
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 EMPLOYEE BENEFITS				4.00
5.01 DATA PROCESSING				5.01
5.02 PURCHASING RECEIVING AND STORES				5.02
5.03 ADMITTING				5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE				5.04
5.05 OTHER ADMINISTRATIVE AND GENERAL				5.05
7.00 OPERATION OF PLANT				7.00
8.00 LAUNDRY & LINEN SERVICE				8.00
9.00 HOUSEKEEPING				9.00
10.00 DIETARY				10.00
11.00 CAFETERIA				11.00
13.00 NURSING ADMINISTRATION				13.00
14.00 CENTRAL SERVICES & SUPPLY				14.00
15.00 PHARMACY				15.00
16.00 MEDICAL RECORDS & LIBRARY				16.00
17.00 SOCIAL SERVICE				17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	270,118	0	270,118	30.00
43.00 NURSERY	8,639	0	8,639	43.00
44.00 SKILLED NURSING FACILITY	142,295	0	142,295	44.00
46.00 OTHER LONG TERM CARE	182,148	0	182,148	46.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	350,015	0	350,015	50.00
52.00 DELIVERY ROOM & LABOR ROOM	7,555	0	7,555	52.00
53.00 ANESTHESIOLOGY	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	193,595	0	193,595	54.00
60.00 LABORATORY	69,527	0	69,527	60.00
66.00 PHYSICAL THERAPY	89,910	0	89,910	66.00
67.00 OCCUPATIONAL THERAPY	38,394	0	38,394	67.00
68.00 SPEECH PATHOLOGY	9,955	0	9,955	68.00
69.00 ELECTROCARDIOLOGY	97,278	0	97,278	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	857	0	857	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	18,778	0	18,778	72.00
73.00 DRUGS CHARGED TO PATIENTS	39,305	0	39,305	73.00
76.00 DURABLE MEDICAL EQUIPMENT	0	0	0	76.00
76.01 SLEEP LAB	11,280	0	11,280	76.01
76.02 IV THERAPY	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
90.00 CLINIC	76,813	0	76,813	90.00
91.00 EMERGENCY	128,229	0	128,229	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10 CORF	0	0	0	99.10
101.00 HOME HEALTH AGENCY	43,335	0	43,335	101.00
SPECIAL PURPOSE COST CENTERS				
113.00 INTEREST EXPENSE	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,778,026	0	1,778,026	118.00
NONREIMBURSABLE COST CENTERS				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,497	0	10,497	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	51,269	0	51,269	192.00
192.02 ORTHO CLINIC	14,416	0	14,416	192.02
192.03 LEASED SPACE	153,095	0	153,095	192.03
194.00 OTHER NONREIMBURSABLE COST CENTERS	31,186	0	31,186	194.00
194.01 PHYSICIAN BILLING COSTS	4,873	0	4,873	194.01
194.02 KELLY MEDICAL RENTAL AREA	5,994	0	5,994	194.02
194.03 ANESTHESIA BILLING	2,914	0	2,914	194.03
194.04 SPECIALTY CLINIC	39	0	39	194.04
194.05 COLONA CLINIC	5,969	0	5,969	194.05
200.00 Cross Foot Adjustments	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	2,058,278	0	2,058,278	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet B-1

Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description	CAPITAL RELATED COSTS					
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COST)	
	1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	150,956				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		749,879			2.00
4.00	EMPLOYEE BENEFITS	307	73	10,752,216		4.00
5.01	DATA PROCESSING	1,408	150,695	283,205	51,775	5.01
5.02	PURCHASING RECEIVING AND STORES	3,246	107	108,000	75	5.02
5.03	ADMITTING	794	2,439	140,034	0	5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE	2,001	2,113	224,802	1,075	5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	14,788	36,200	465,125	3,550	5.05
7.00	OPERATION OF PLANT	15,009	40,355	184,354	0	7.00
8.00	LAUNDRY & LINEN SERVICE	1,082	111	25,466	0	8.00
9.00	HOUSEKEEPING	857	3,032	313,149	0	9.00
10.00	DIETARY	5,766	12,609	447,580	125	10.00
11.00	CAFETERIA	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	145	278	120,794	2,325	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	PHARMACY	1,384	3,223	177,081	1,850	15.00
16.00	MEDICAL RECORDS & LIBRARY	2,899	9,070	282,926	3,475	16.00
17.00	SOCIAL SERVICE	348	0	200,139	175	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	14,593	47,715	1,682,852	4,025	30.00
43.00	NURSERY	0	6,291	147,393	0	43.00
44.00	SKILLED NURSING FACILITY	10,436	3,611	403,374	1,600	44.00
46.00	OTHER LONG TERM CARE	13,013	5,972	552,147	600	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	13,545	141,931	1,061,034	2,350	50.00
52.00	DELIVERY ROOM & LABOR ROOM	565	0	44,897	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	7,108	65,476	631,855	2,250	54.00
60.00	LABORATORY	1,581	18,901	488,449	1,400	60.00
66.00	PHYSICAL THERAPY	3,254	27,480	780,860	2,350	66.00
67.00	OCCUPATIONAL THERAPY	2,322	1,094	271,346	2,025	67.00
68.00	SPEECH PATHOLOGY	772	555	63,762	0	68.00
69.00	ELECTROCARDIOLOGY	1,549	63,989	292,164	1,350	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	DURABLE MEDICAL EQUIPMENT	0	0	0	0	76.00
76.01	SLEEP LAB	528	2,643	74,461	0	76.01
76.02	IV THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	CLINIC	0	52,810	119,011	5,294	90.00
91.00	EMERGENCY	3,392	37,350	452,266	10,100	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	1,250	4,417	431,055	5,450	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	123,942	740,540	10,469,581	51,444	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,000	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	4,640	2,379	0	0	192.00
192.02	ORTHO CLINIC	316	6,960	64,838	0	192.02
192.03	LEASED SPACE	17,516	0	24,118	0	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	2,971	0	0	0	194.00
194.01	PHYSICIAN BILLING COSTS	0	0	0	0	194.01
194.02	KELLY MEDICAL RENTAL AREA	571	0	0	0	194.02
194.03	ANESTHESIA BILLING	0	0	0	0	194.03
194.04	SPECIALTY CLINIC	0	0	3,620	0	194.04
194.05	COLONA CLINIC	0	0	190,059	331	194.05
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)	1,291,867	766,411	3,099,271	900,354	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	8.557904	1.022046	0.288245	17.389744	203.00
204.00	Cost to be allocated (per wkst. B, Part II)			2,702	166,139	204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.000251	3.208865	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet B-1

Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	5.03	5.04	5A.05	5.05	7.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 DATA PROCESSING						5.01
5.02 PURCHASING RECEIVING AND STORES						5.02
5.03 ADMITTING	52,365,070					5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE	0	55,146,239				5.04
5.05 OTHER ADMINISTRATIVE AND GENERAL	0	0	-2,203,289	23,916,935		5.05
7.00 OPERATION OF PLANT	0	0	0	1,220,347	95,571	7.00
8.00 LAUNDRY & LINEN SERVICE	0	0	0	154,796	1,082	8.00
9.00 HOUSEKEEPING	0	0	0	502,008	857	9.00
10.00 DIETARY	0	0	0	888,648	5,766	10.00
11.00 CAFETERIA	0	0	0	0	0	11.00
13.00 NURSING ADMINISTRATION	0	0	0	202,178	145	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	1,499	0	14.00
15.00 PHARMACY	0	0	0	455,788	1,384	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	521,965	2,899	16.00
17.00 SOCIAL SERVICE	0	0	0	267,633	348	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,855,239	2,855,239	0	2,660,494	14,593	30.00
43.00 NURSERY	293,681	293,681	0	200,556	0	43.00
44.00 SKILLED NURSING FACILITY	416,152	416,152	0	684,407	10,436	44.00
46.00 OTHER LONG TERM CARE	1,662,246	1,662,246	0	908,652	13,013	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	10,199,763	10,199,763	0	2,757,742	13,545	50.00
52.00 DELIVERY ROOM & LABOR ROOM	385,687	385,687	0	67,464	565	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	11,042,284	11,042,284	0	2,558,696	7,108	54.00
60.00 LABORATORY	5,730,691	5,730,691	0	1,553,101	1,581	60.00
66.00 PHYSICAL THERAPY	3,079,249	3,079,249	0	1,156,280	3,254	66.00
67.00 OCCUPATIONAL THERAPY	1,034,855	1,034,855	0	433,869	2,322	67.00
68.00 SPEECH PATHOLOGY	148,457	148,457	0	96,432	772	68.00
69.00 ELECTROCARDIOLOGY	2,744,608	2,616,603	0	674,598	1,549	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	350,906	350,906	0	4,359	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,408,743	1,408,743	0	1,048,894	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	4,112,390	4,112,390	0	567,384	0	73.00
76.00 DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	76.00
76.01 SLEEP LAB	672,458	672,458	0	156,698	528	76.01
76.02 IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 CLINIC	0	622,920	0	512,243	0	90.00
91.00 EMERGENCY	4,909,365	2,872,995	0	1,471,672	3,392	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	0	754,070	0	774,472	1,250	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	51,046,774	50,259,389	-2,203,289	22,502,875	86,389	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	8,558	1,000	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	57,699	4,640	192.00
192.02 ORTHO CLINIC	0	0	0	535,669	0	192.02
192.03 LEASED SPACE	0	0	0	276,275	0	192.03
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	25,426	2,971	194.00
194.01 PHYSICIAN BILLING COSTS	0	3,183,967	0	27,484	0	194.01
194.02 KELLY MEDICAL RENTAL AREA	0	0	0	4,887	571	194.02
194.03 ANESTHESIA BILLING	1,318,296	1,318,296	0	20,165	0	194.03
194.04 SPECIALTY CLINIC	0	0	0	5,055	0	194.04
194.05 COLONA CLINIC	0	384,587	0	452,842	0	194.05
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)	198,518	476,047		2,203,289	1,332,769	202.00
203.00 Unit cost multiplier (wkst. B, Part I)	0.003791	0.008632		0.092123	13.945329	203.00
204.00 Cost to be allocated (per wkst. B, Part II)	9,376	22,865		176,015	179,276	204.00
205.00 Unit cost multiplier (wkst. B, Part II)	0.000179	0.000415		0.007359	1.875841	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet B-1

Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	DATA PROCESSING						5.01
5.02	PURCHASING RECEIVING AND STORES						5.02
5.03	ADMITTING						5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE	287,704					8.00
9.00	HOUSEKEEPING	23,494	479,521				9.00
10.00	DIETARY	1,752	9,125	163,420			10.00
11.00	CAFETERIA	0	17,275	109,783	15,514		11.00
13.00	NURSING ADMINISTRATION	0	0	0	100	12,177	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	5,925	0	280	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	4,250	0	910	0	16.00
17.00	SOCIAL SERVICE	0	1,490	0	379	379	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	57,575	128,216	11,313	3,205	3,205	30.00
43.00	NURSERY	0	3,525	0	18	18	43.00
44.00	SKILLED NURSING FACILITY	34,523	66,450	14,512	1,111	1,111	44.00
46.00	OTHER LONG TERM CARE	79,459	56,125	27,812	1,788	1,602	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	36,090	73,175	0	1,758	1,758	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	525	0	112	112	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	16,634	7,900	0	1,121	1,113	54.00
60.00	LABORATORY	0	6,450	0	1,105	1,074	60.00
66.00	PHYSICAL THERAPY	16,324	6,115	0	1,530	0	66.00
67.00	OCCUPATIONAL THERAPY	0	2,675	0	415	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	100	0	68.00
69.00	ELECTROCARDIOLOGY	0	5,775	0	454	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES 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	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	76.00
76.01	SLEEP LAB	1,951	0	0	149	149	76.01
76.02	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	CLINIC	0	13,000	0	0	0	90.00
91.00	EMERGENCY	17,305	21,200	0	798	798	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	3,325	0	0	858	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	285,107	432,521	163,420	15,333	12,177	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	ORTHO CLINIC	0	0	0	181	0	192.02
192.03	LEASED SPACE	2,597	28,800	0	0	0	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	ANESTHESIA BILLING	0	0	0	0	0	194.03
194.04	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	COLONA CLINIC	0	18,200	0	0	0	194.05
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)	184,145	575,242	1,062,990	734,824	227,562	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	0.640050	1.199618	6.504651	47.365219	18.687854	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	12,577	17,337	80,876	54,956	11,131	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.043715	0.036155	0.494897	3.542349	0.914100	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet B-1

Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.01	DATA PROCESSING					5.01
5.02	PURCHASING RECEIVING AND STORES					5.02
5.03	ADMITTING					5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL					5.05
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
14.00	CENTRAL SERVICES & SUPPLY	100				14.00
15.00	PHARMACY	0	100			15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	55,146,239		16.00
17.00	SOCIAL SERVICE	0	0	0	81,100	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	0	2,855,239	32,000	30.00
43.00	NURSERY	0	0	293,681	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	416,152	25,250	44.00
46.00	OTHER LONG TERM CARE	0	0	1,662,246	14,500	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	10,199,763	350	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	385,687	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	11,042,284	0	54.00
60.00	LABORATORY	0	0	5,730,691	0	60.00
66.00	PHYSICAL THERAPY	0	0	3,079,249	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	1,034,855	0	67.00
68.00	SPEECH PATHOLOGY	0	0	148,457	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	2,616,603	150	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	100	0	350,906	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	1,408,743	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	100	4,112,390	0	73.00
76.00	DURABLE MEDICAL EQUIPMENT	0	0	0	0	76.00
76.01	SLEEP LAB	0	0	672,458	0	76.01
76.02	IV THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	CLINIC	0	0	622,920	3,900	90.00
91.00	EMERGENCY	0	0	2,872,995	2,875	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	754,070	2,075	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	100	100	50,259,389	81,100	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.02	ORTHO CLINIC	0	0	0	0	192.02
192.03	LEASED SPACE	0	0	0	0	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	PHYSICIAN BILLING COSTS	0	0	3,183,967	0	194.01
194.02	KELLY MEDICAL RENTAL AREA	0	0	0	0	194.02
194.03	ANESTHESIA BILLING	0	0	1,318,296	0	194.03
194.04	SPECIALTY CLINIC	0	0	0	0	194.04
194.05	COLONA CLINIC	0	0	384,587	0	194.05
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)	1,637	537,447	658,678	323,962	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	16.370000	5,374.470000	0.011944	3.994599	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	247	28,361	58,018	7,959	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	2.470000	283.610000	0.001052	0.098138	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet C
Part I
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		Total Costs
			Total Costs	RCE Disallowance	Costs		
					Total Costs	Total Costs	
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	3,746,967		3,746,967	0	3,746,967	30.00	
43.00 NURSERY	227,958		227,958	0	227,958	43.00	
44.00 SKILLED NURSING FACILITY	1,268,416		1,268,416	0	1,268,416	44.00	
46.00 OTHER LONG TERM CARE	1,665,329		1,665,329	0	1,665,329	46.00	
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	3,550,899		3,550,899	0	3,550,899	50.00	
52.00 DELIVERY ROOM & LABOR ROOM	94,193		94,193	0	94,193	52.00	
53.00 ANESTHESIOLOGY	0		0	0	0	53.00	
54.00 RADIOLOGY-DIAGNOSTIC	3,119,453		3,119,453	0	3,119,453	54.00	
60.00 LABORATORY	1,866,820		1,866,820	0	1,866,820	60.00	
66.00 PHYSICAL THERAPY	1,435,210	0	1,435,210	0	1,435,210	66.00	
67.00 OCCUPATIONAL THERAPY	541,445	0	541,445	0	541,445	67.00	
68.00 SPEECH PATHOLOGY	122,592	0	122,592	0	122,592	68.00	
69.00 ELECTROCARDIOLOGY	818,629		818,629	0	818,629	69.00	
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	10,589		10,589	0	10,589	71.00	
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,162,347		1,162,347	0	1,162,347	72.00	
73.00 DRUGS CHARGED TO PATIENTS	1,206,218		1,206,218	0	1,206,218	73.00	
76.00 DURABLE MEDICAL EQUIPMENT	0		0	0	0	76.00	
76.01 SLEEP LAB	197,618		197,618	0	197,618	76.01	
76.02 IV THERAPY	0		0	0	0	76.02	
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0		0	0	0	88.00	
90.00 CLINIC	598,046		598,046	0	598,046	90.00	
91.00 EMERGENCY	1,789,567		1,789,567	0	1,789,567	91.00	
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	596,744		596,744	0	596,744	92.00	
OTHER REIMBURSABLE COST CENTERS							
99.10 CORF	0		0	0	0	99.10	
101.00 HOME HEALTH AGENCY	900,570		900,570	0	900,570	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00 INTEREST EXPENSE						113.00	
200.00 Subtotal (see instructions)	24,919,610	0	24,919,610	0	24,919,610	200.00	
201.00 Less Observation Beds	596,744		596,744		596,744	201.00	
202.00 Total (see instructions)	24,322,866	0	24,322,866	0	24,322,866	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet C
Part I
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description	Title XVIII			Hospital	Cost	
	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS					30.00
43.00	NURSERY	2,383,632		2,383,632		43.00
44.00	SKILLED NURSING FACILITY	293,681		293,681		44.00
46.00	OTHER LONG TERM CARE	416,152		416,152		44.00
		1,658,830		1,658,830		46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	3,332,816	6,866,947	10,199,763	0.348135	50.00
52.00	DELIVERY ROOM & LABOR ROOM	335,205	50,482	385,687	0.244221	52.00
53.00	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,152,925	9,889,359	11,042,284	0.282501	54.00
60.00	LABORATORY	1,304,235	4,426,456	5,730,691	0.325758	60.00
66.00	PHYSICAL THERAPY	559,859	2,519,390	3,079,249	0.466091	66.00
67.00	OCCUPATIONAL THERAPY	263,084	771,771	1,034,855	0.523209	67.00
68.00	SPEECH PATHOLOGY	37,682	110,775	148,457	0.825774	68.00
69.00	ELECTROCARDIOLOGY	274,234	2,342,369	2,616,603	0.312859	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	277,330	73,576	350,906	0.030176	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,141,294	267,449	1,408,743	0.825095	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,980,550	1,131,840	4,112,390	0.293313	73.00
76.00	DURABLE MEDICAL EQUIPMENT	0	0	0	0.000000	76.00
76.01	SLEEP LAB	1,000	671,458	672,458	0.293874	76.01
76.02	IV THERAPY	0	0	0	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	CLINIC	0	274,364	274,364	2.179754	90.00
91.00	EMERGENCY	428,248	2,444,747	2,872,995	0.622892	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1,000	470,607	471,607	1.265342	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0		99.10
101.00	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	16,841,757	32,311,590	49,153,347		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	16,841,757	32,311,590	49,153,347		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet C
Part I
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
43.00	NURSERY				43.00
44.00	SKILLED NURSING FACILITY				44.00
46.00	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	DURABLE MEDICAL EQUIPMENT	0.000000			76.00
76.01	SLEEP LAB	0.000000			76.01
76.02	IV THERAPY	0.000000			76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC				88.00
90.00	CLINIC	0.000000			90.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	CORF				99.10
101.00	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE				113.00
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: 141319		Period: From 06/01/2010 To 05/31/2011		Worksheet D Part II Date/Time Prepared: 11/29/2011 8:53 am	
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	350,015	10,199,763	0.034316	1,507,541	51,733	50.00
52.00	DELIVERY ROOM & LABOR ROOM	7,555	385,687	0.019588	62	1	52.00
53.00	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	193,595	11,042,284	0.017532	263,358	4,617	54.00
60.00	LABORATORY	69,527	5,730,691	0.012132	498,118	6,043	60.00
66.00	PHYSICAL THERAPY	89,910	3,079,249	0.029199	123,755	3,614	66.00
67.00	OCCUPATIONAL THERAPY	38,394	1,034,855	0.037101	63,912	2,371	67.00
68.00	SPEECH PATHOLOGY	9,955	148,457	0.067056	9,259	621	68.00
69.00	ELECTROCARDIOLOGY	97,278	2,616,603	0.037177	100,906	3,751	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	857	350,906	0.002442	180,137	440	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	18,778	1,408,743	0.013330	712,480	9,497	72.00
73.00	DRUGS CHARGED TO PATIENTS	39,305	4,112,390	0.009558	1,275,339	12,190	73.00
76.00	DURABLE MEDICAL EQUIPMENT	0	0	0.000000	0	0	76.00
76.01	SLEEP LAB	11,280	672,458	0.016774	0	0	76.01
76.02	IV THERAPY	0	0	0.000000	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	CLINIC	76,813	274,364	0.279967	0	0	90.00
91.00	EMERGENCY	128,229	2,872,995	0.044633	5,846	261	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	471,607	0.000000	608	0	92.00
200.00	Total (lines 50-199)	1,131,491	44,401,052		4,741,321	95,139	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet D
Part IV
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description	Title XVIII				Hospital	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All other Medical Education Cost	Cost		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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	IMPLANTABLE DEVICES 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	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	76.00
76.01	SLEEP LAB	0	0	0	0	0	76.01
76.02	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet D
Part IV
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description	Title XVIII			Hospital		Cost
	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	10,199,763	0.000000	0.000000	1,507,541	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	385,687	0.000000	0.000000	62	52.00
53.00 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	11,042,284	0.000000	0.000000	263,358	54.00
60.00 LABORATORY	0	5,730,691	0.000000	0.000000	498,118	60.00
66.00 PHYSICAL THERAPY	0	3,079,249	0.000000	0.000000	123,755	66.00
67.00 OCCUPATIONAL THERAPY	0	1,034,855	0.000000	0.000000	63,912	67.00
68.00 SPEECH PATHOLOGY	0	148,457	0.000000	0.000000	9,259	68.00
69.00 ELECTROCARDIOLOGY	0	2,616,603	0.000000	0.000000	100,906	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	350,906	0.000000	0.000000	180,137	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	1,408,743	0.000000	0.000000	712,480	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	4,112,390	0.000000	0.000000	1,275,339	73.00
76.00 DURABLE MEDICAL EQUIPMENT	0	0	0.000000	0.000000	0	76.00
76.01 SLEEP LAB	0	672,458	0.000000	0.000000	0	76.01
76.02 IV THERAPY	0	0	0.000000	0.000000	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00 CLINIC	0	274,364	0.000000	0.000000	0	90.00
91.00 EMERGENCY	0	2,872,995	0.000000	0.000000	5,846	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	471,607	0.000000	0.000000	608	92.00
200.00 Total (lines 50-199)	0	44,401,052			4,741,321	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet D
Part IV
Date/Time Prepared:
11/29/2011 8:53 am

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
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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 IMPLANTABLE DEVICES 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 DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	76.00
76.01 SLEEP LAB	0	0	0	0	0	76.01
76.02 IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 141319	Period: From 06/01/2010 To 05/31/2011	Worksheet D Part IV Date/Time Prepared: 11/29/2011 8:53 am
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Cost Center Description	Title XVIII		Hospital	Cost
	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
	23.00	24.00		
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 ANESTHESIOLOGY	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0		54.00
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 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00 DURABLE MEDICAL EQUIPMENT	0	0		76.00
76.01 SLEEP LAB	0	0		76.01
76.02 IV THERAPY	0	0		76.02
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0		88.00
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
200.00 Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141319	Period: From 06/01/2010 To 05/31/2011	Worksheet D Part v Date/Time Prepared: 11/29/2011 8:53 am
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Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges		Cost
			Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
			1.00	2.00	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.348135	0	2,277,947	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.244221	0	183	0	52.00
53.00 ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.282501	0	3,546,762	0	54.00
60.00 LABORATORY	0.325758	0	2,230,444	0	60.00
66.00 PHYSICAL THERAPY	0.466091	0	752,895	0	66.00
67.00 OCCUPATIONAL THERAPY	0.523209	0	196,322	0	67.00
68.00 SPEECH PATHOLOGY	0.825774	0	11,064	0	68.00
69.00 ELECTROCARDIOLOGY	0.312859	0	1,192,813	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.030176	0	71,180	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.825095	0	49,359	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.293313	0	756,056	6,832	73.00
76.00 DURABLE MEDICAL EQUIPMENT	0.000000	0	0	0	76.00
76.01 SLEEP LAB	0.293874	0	227,938	0	76.01
76.02 IV THERAPY	0.000000	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
90.00 CLINIC	2.179754	0	138,664	0	90.00
91.00 EMERGENCY	0.622892	0	953,304	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.265342	0	235,687	0	92.00
200.00 Subtotal (see instructions)		0	12,640,618	6,832	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0	0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	12,640,618	6,832	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet D
Part V
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description		Title XVIII			Hospital	Cost
		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	793,033	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	45	0		52.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	1,001,964	0		54.00
60.00	LABORATORY	0	726,585	0		60.00
66.00	PHYSICAL THERAPY	0	350,918	0		66.00
67.00	OCCUPATIONAL THERAPY	0	102,717	0		67.00
68.00	SPEECH PATHOLOGY	0	9,136	0		68.00
69.00	ELECTROCARDIOLOGY	0	373,182	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,148	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	40,726	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	221,761	2,004		73.00
76.00	DURABLE MEDICAL EQUIPMENT	0	0	0		76.00
76.01	SLEEP LAB	0	66,985	0		76.01
76.02	IV THERAPY	0	0	0		76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	CLINIC	0	302,253	0		90.00
91.00	EMERGENCY	0	593,805	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	298,225	0		92.00
200.00	Subtotal (see instructions)	0	4,883,483	2,004		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	4,883,483	2,004		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet D
Part V
Date/Time Prepared:
11/29/2011 8:53 am

Component CCN: 142319

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
	1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.348135	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.244221	0	0	0	52.00
53.00 ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.282501	0	0	0	54.00
60.00 LABORATORY	0.325758	0	0	0	60.00
66.00 PHYSICAL THERAPY	0.466091	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0.523209	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0.825774	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0.312859	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.030176	0	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.825095	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.293313	0	0	0	73.00
76.00 DURABLE MEDICAL EQUIPMENT	0.000000	0	0	0	76.00
76.01 SLEEP LAB	0.293874	0	0	0	76.01
76.02 IV THERAPY	0.000000	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0.000000				88.00
90.00 CLINIC	2.179754	0	0	0	90.00
91.00 EMERGENCY	0.622892	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.265342	0	0	0	92.00
200.00 Subtotal (see instructions)		0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141319	Period: From 06/01/2010 To 05/31/2011	Worksheet D Part V Date/Time Prepared: 11/29/2011 8:53 am
	Component CCN: 142319	Title XVIII	Swing Beds - SNF

Cost Center Description	Costs			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	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
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 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00 DURABLE MEDICAL EQUIPMENT	0	0	0	76.00
76.01 SLEEP LAB	0	0	0	76.01
76.02 IV THERAPY	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
90.00 CLINIC	0	0	0	90.00
91.00 EMERGENCY	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
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 INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet D
Part IV
Date/Time Prepared:
11/29/2011 8:53 am

Component CCN: 145464

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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 IMPLANTABLE DEVICES 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 DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	76.00
76.01 SLEEP LAB	0	0	0	0	0	76.01
76.02 IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 141319	Period: From 06/01/2010 To 05/31/2011	Worksheet D Part IV Date/Time Prepared: 11/29/2011 8:53 am
	Component CCN: 145464	Title XVIII	Skilled Nursing Facility PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	10,199,763	0.000000	0.000000	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	385,687	0.000000	0.000000	0	52.00
53.00 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	11,042,284	0.000000	0.000000	13,769	54.00
60.00 LABORATORY	0	5,730,691	0.000000	0.000000	32,626	60.00
66.00 PHYSICAL THERAPY	0	3,079,249	0.000000	0.000000	228,540	66.00
67.00 OCCUPATIONAL THERAPY	0	1,034,855	0.000000	0.000000	105,233	67.00
68.00 SPEECH PATHOLOGY	0	148,457	0.000000	0.000000	22,475	68.00
69.00 ELECTROCARDIOLOGY	0	2,616,603	0.000000	0.000000	1,953	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	350,906	0.000000	0.000000	988	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	1,408,743	0.000000	0.000000	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	4,112,390	0.000000	0.000000	122,881	73.00
76.00 DURABLE MEDICAL EQUIPMENT	0	0	0.000000	0.000000	0	76.00
76.01 SLEEP LAB	0	672,458	0.000000	0.000000	616	76.01
76.02 IV THERAPY	0	0	0.000000	0.000000	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00 CLINIC	0	274,364	0.000000	0.000000	0	90.00
91.00 EMERGENCY	0	2,872,995	0.000000	0.000000	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	471,607	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	44,401,052			529,081	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319
Component CCN: 145464

Period:
From 06/01/2010
To 05/31/2011

Worksheet D
Part IV
Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description		Title XVIII			Skilled Nursing Facility	PPS	
		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	
ANCILLARY SERVICE COST CENTERS		11.00	12.00	13.00	21.00	22.00	
50.00	OPERATING ROOM	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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	IMPLANTABLE DEVICES 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	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	76.00
76.01	SLEEP LAB	0	0	0	0	0	76.01
76.02	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet D
Part IV
Date/Time Prepared:
11/29/2011 8:53 am

Component CCN: 145464

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description	PSA Adj.	PSA Adj. All		
	Allied Health	Other Medical Education 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
53.00 ANESTHESIOLOGY	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0		54.00
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 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00 DURABLE MEDICAL EQUIPMENT	0	0		76.00
76.01 SLEEP LAB	0	0		76.01
76.02 IV THERAPY	0	0		76.02
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0		88.00
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
200.00 Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141319	Period: From 06/01/2010 To 05/31/2011	Worksheet D Part V Date/Time Prepared: 11/29/2011 8:53 am
	Component CCN: 145464	Title XVIII	Skilled Nursing Facility PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges			
			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	0.348135	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.244221	0	0	0	52.00
53.00	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.282501	0	0	0	54.00
60.00	LABORATORY	0.325758	0	0	0	60.00
66.00	PHYSICAL THERAPY	0.466091	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.523209	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0.825774	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.312859	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.030176	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.825095	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.293313	0	0	0	73.00
76.00	DURABLE MEDICAL EQUIPMENT	0.000000	0	0	0	76.00
76.01	SLEEP LAB	0.293874	0	0	0	76.01
76.02	IV THERAPY	0.000000	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000				88.00
90.00	CLINIC	2.179754	0	0	0	90.00
91.00	EMERGENCY	0.622892	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.265342	0	0	0	92.00
200.00	Subtotal (see instructions)		0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141319 Component CCN: 145464	Period: From 06/01/2010 To 05/31/2011	Worksheet D Part V Date/Time Prepared: 11/29/2011 8:53 am
	Title XVIII	Skilled Nursing Facility	PPS

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
53.00 ANESTHESIOLOGY	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
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 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00 DURABLE MEDICAL EQUIPMENT	0	0	0	76.00
76.01 SLEEP LAB	0	0	0	76.01
76.02 IV THERAPY	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
90.00 CLINIC	0	0	0	90.00
91.00 EMERGENCY	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
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: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet D-1

Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description		Title XVIII	Hospital	Cost	
PART I - ALL PROVIDER COMPONENTS				1.00	
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,893	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,527	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)			3,527	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			214	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)			152	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			1,625	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)			189	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)			133	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			112.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			115.36	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			119.20	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			122.78	20.00
21.00	Total general inpatient routine service cost (see instructions)			3,746,967	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)			23,968	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)			17,535	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)			352,271	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,394,696	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed charges)			2,586,969	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			2,586,969	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			1.312229	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)			733.48	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			3,394,696	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)			962.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,564,046	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)			1,564,046	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet D-1

Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description	Title XVIII			Hospital		Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT							43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)						1.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						1,863,627	48.00
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)						181,911	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						128,011	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						309,922	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)						620	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						962.49	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						596,744	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet D-1

Date/Time Prepared:
11/29/2011 8:53 am

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: 141319	Period: From 06/01/2010 To 05/31/2011	Worksheet D-1
	Component CCN: 145464		Date/Time Prepared: 11/29/2011 8:53 am
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description			
		1.00	
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,001	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,001	2.00
3.00	Private room days (excluding swing-bed and observation bed days)	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,001	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,127	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	112.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	112.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	112.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,268,416	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,268,416	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)	416,152	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	416,152	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	3.047963	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)	83.21	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)	1,268,416	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141319	Period: From 06/01/2010 To 05/31/2011	Worksheet D-1			
		Component CCN: 145464		Date/Time Prepared: 11/29/2011 8:53 am			
		Title XVIII	Skilled Nursing Facility	PPS			
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1.00	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					1,268,416	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					253.63	71.00
72.00	Program routine service cost (line 9 x line 71)					285,841	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					285,841	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					285,841	83.00
84.00	Program inpatient ancillary services (see instructions)					231,521	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					517,362	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: 141319	Period: From 06/01/2010 To 05/31/2011	Worksheet D-1
		Component CCN: 145464		Date/Time Prepared: 11/29/2011 8:53 am
Title XVIII			Skilled Nursing Facility	PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141319	Period: From 06/01/2010 To 05/31/2011	worksheet D-3	Date/Time Prepared: 11/29/2011 8:53 am
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				30.00
43.00	NURSERY		1,290,465		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.348135	1,507,541	524,828	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.244221	62	15	52.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.282501	263,358	74,399	54.00
60.00	LABORATORY	0.325758	498,118	162,266	60.00
66.00	PHYSICAL THERAPY	0.466091	123,755	57,681	66.00
67.00	OCCUPATIONAL THERAPY	0.523209	63,912	33,439	67.00
68.00	SPEECH PATHOLOGY	0.825774	9,259	7,646	68.00
69.00	ELECTROCARDIOLOGY	0.312859	100,906	31,569	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.030176	180,137	5,436	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.825095	712,480	587,864	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.293313	1,275,339	374,074	73.00
76.00	DURABLE MEDICAL EQUIPMENT	0.000000	0	0	76.00
76.01	SLEEP LAB	0.293874	0	0	76.01
76.02	IV THERAPY	0.000000	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	CLINIC	2.179754	0	0	90.00
91.00	EMERGENCY	0.622892	5,846	3,641	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.265342	608	769	92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,741,321	1,863,627	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		4,741,321		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141319 Period: From 06/01/2010 To 05/31/2011 Worksheet D-3
 Component CCN: 142319 Date/Time Prepared: 11/29/2011 8:53 am

Cost Center Description	Title XVIII			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				30.00
43.00 NURSERY		125,815		43.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0.348135	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.244221	0	0	52.00
53.00 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.282501	4,958	1,401	54.00
60.00 LABORATORY	0.325758	21,879	7,127	60.00
66.00 PHYSICAL THERAPY	0.466091	81,361	37,922	66.00
67.00 OCCUPATIONAL THERAPY	0.523209	33,904	17,739	67.00
68.00 SPEECH PATHOLOGY	0.825774	1,587	1,311	68.00
69.00 ELECTROCARDIOLOGY	0.312859	3,450	1,079	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.030176	2,110	64	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.825095	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.293313	59,126	17,342	73.00
76.00 DURABLE MEDICAL EQUIPMENT	0.000000	0	0	76.00
76.01 SLEEP LAB	0.293874	0	0	76.01
76.02 IV THERAPY	0.000000	0	0	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00 CLINIC	2.179754	0	0	90.00
91.00 EMERGENCY	0.622892	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.265342	0	0	92.00
200.00 Total (sum of lines 50-94 and 96-98)		208,375	83,985	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)		208,375		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141319	Period: From 06/01/2010 To 05/31/2011	worksheet D-3
		Component CCN: 145464		Date/Time Prepared: 11/29/2011 8:53 am
Cost Center Description		Title XVIII	Skilled Nursing Facility	PPS
		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			30.00
43.00	NURSERY		341,013	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.348135	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.244221	0	52.00
53.00	ANESTHESIOLOGY	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.282501	13,769	54.00
60.00	LABORATORY	0.325758	32,626	60.00
66.00	PHYSICAL THERAPY	0.466091	228,540	66.00
67.00	OCCUPATIONAL THERAPY	0.523209	105,233	67.00
68.00	SPEECH PATHOLOGY	0.825774	22,475	68.00
69.00	ELECTROCARDIOLOGY	0.312859	1,953	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.030176	988	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.825095	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.293313	122,881	73.00
76.00	DURABLE MEDICAL EQUIPMENT	0.000000	0	76.00
76.01	SLEEP LAB	0.293874	616	76.01
76.02	IV THERAPY	0.000000	0	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	CLINIC	2.179754	0	90.00
91.00	EMERGENCY	0.622892	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.265342	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		529,081	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		529,081	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141319	Period: From 06/01/2010 To 05/31/2011	Worksheet E Part B Date/Time Prepared: 11/29/2011 8:53 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,885,487	1.00
3.00	PPS payments		0	2.00
4.00	Outlier payment (see instructions)		0	3.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0	4.00
6.00	Line 2 times line 5		0.000	5.00
7.00	Sum of line 3 plus line 4 divided by line 6		0	6.00
8.00	Transitional corridor payment (see instructions)		0.00	7.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200		0	8.00
10.00	Organ acquisitions		0	9.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		4,885,487	10.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		4,934,342	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)		56,551	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,079,061	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		2,798,730	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,798,730	30.00
31.00	Primary payer payments		1,484	31.00
32.00	Subtotal (line 30 minus line 31)		2,797,246	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)		44,569	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		44,569	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		2,841,815	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)		2,841,815	40.00
41.00	Interim payments		3,175,004	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)		-333,189	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: 141319	Period: From 06/01/2010 To 05/31/2011	Worksheet E Part B Date/Time Prepared: 11/29/2011 8:53 am
	Title XVIII	Hospital	Cost
			Overrides 1.00
WORKSHEET OVERRIDE VALUES			
112.00 Override of Ancillary service charges (line 12)			0 112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141319	Period: From 06/01/2010 To 05/31/2011	Worksheet E Part B Date/Time Prepared: 11/29/2011 8:53 am
	Component CCN: 145464	Title XVIII	Skilled Nursing Facility PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141319 Component CCN: 145464	Period: From 06/01/2010 To 05/31/2011	Worksheet E Part B Date/Time Prepared: 11/29/2011 8:53 am
	Title XVIII	Skilled Nursing Facility	PPS
			Overrides
			1.00
<p>WORKSHEET OVERRIDE VALUES</p> 112.00 override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet E-1
Part I
Date/Time Prepared:
11/29/2011 8:53 am

		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						
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		2,579,253		3,034,117	1.00	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)		0		0		3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	12/17/2010	33,868	12/17/2010	98,292	3.01	
3.02		05/20/2011	21,226	05/20/2011	42,595	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		55,094		140,887	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		2,634,347		3,175,004	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		399,612		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		333,189	6.02	
7.00	Total Medicare program liability (see instructions)		3,033,959		2,841,815	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor		0				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141319 Period: From 06/01/2010 To 05/31/2011
 Component CCN: 142319 Worksheet E-1 Part I
 Date/Time Prepared: 11/29/2011 8:53 am

		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						
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		349,497		0	1.00	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	12/17/2010	22,401		0	3.01	
3.02		05/20/2011	6,682		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		29,083		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)		378,580		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		18,138		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		396,718		0	7.00	
		0		Contractor Number	Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141319	Period: From 06/01/2010 To 05/31/2011	Worksheet E-1 Part I Date/Time Prepared: 11/29/2011 8:53 am
Component CCN: 145464	Title XVIII	Skilled Nursing Facility PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1.00	Total interim payments paid to provider	1.00	2.00	3.00	4.00	
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		350,331.00		0.00	1.00 2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		350,331		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		350,331		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: 141319 Period: From 06/01/2010 To 05/31/2011 Worksheet E-2
 Component CCN: 142319 Date/Time Prepared: 11/29/2011 8:53 am

		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)	313,021	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)	84,825	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				
6.00	Interns and residents not in approved teaching program (see instructions)	322	0	5.00	
7.00	Utilization review - physician compensation - SNF optional method only		0	6.00	
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		7.00	
9.00	Primary payer payments (see instructions)	397,846	0	8.00	
10.00	Subtotal (line 8 minus line 9)	0	0	9.00	
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	397,846	0	10.00	
12.00	Subtotal (line 10 minus line 11)	0	0	11.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	397,846	0	12.00	
14.00	80% of Part B costs (line 12 x 80%)	1,128	0	13.00	
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	14.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	396,718	0	15.00	
17.00	Reimbursable bad debts (see instructions)	0	0	16.00	
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	17.00	
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	0	0	18.00	
20.00	Interim payments	396,718	0	19.00	
21.00	Tentative settlement (for contractor use only)	378,580	0	20.00	
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	0	0	21.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	18,138	0	22.00	
		0	0	23.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet E-3
Part V
Date/Time Prepared:
11/29/2011 8:53 am

	Title XVIII	Hospital	Cost	
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			
2.00	Nursing and Allied Health Managed Care payment (see instruction)		3,427,673	1.00
3.00	Organ acquisition		0	2.00
4.00	Subtotal (sum of lines 1 thru 3)		0	3.00
5.00	Primary payer payments		3,427,673	4.00
6.00	Total cost (line 5 less line 6) . For CAH (see instructions)		4,167	5.00
			3,457,741	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)		3,457,741	19.00
20.00	Deductibles (exclude professional component)		423,782	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)		3,033,959	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		3,033,959	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		0	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26(line 26 hospital and subprovider only))		3,033,959	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)		3,033,959	30.00
31.00	Interim payments		2,634,347	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)		399,612	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: 141319	Period:	Worksheet E-3
	Component CCN: 145464	From 06/01/2010 To 05/31/2011	Part VI Date/Time Prepared: 11/29/2011 8:53 am
	Title XVIII	Skilled Nursing Facility	PPS

			1.00	
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		407,509	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		407,509	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services		0	5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		0	7.00
8.00	Allowable bad debts (see instructions)	57,178	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Allowable reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)		350,331	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)		350,331	15.00
16.00	Interim payments		350,331	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2		0	19.00

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

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet G

Date/Time Prepared:
11/29/2011 8:53 am

	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	1,600,110	0	0	0	1.00
2.00 Temporary investments	968,890	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	7,225,791	0	0	0	4.00
5.00 Other receivable	832,188	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-3,727,000	0	0	0	6.00
7.00 Inventory	826,281	0	0	0	7.00
8.00 Prepaid expenses	250,397	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)	7,976,657	0	0	0	11.00
FIXED ASSETS					
12.00 Land	1,139,543	0	0	0	12.00
13.00 Land improvements	713,866	0	0	0	13.00
14.00 Accumulated depreciation	-531,098	0	0	0	14.00
15.00 Buildings	37,773,545	0	0	0	15.00
16.00 Accumulated depreciation	-12,043,786	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	12,222,856	0	0	0	23.00
24.00 Accumulated depreciation	-6,876,067	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)	32,398,859	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	20,561,412	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	2,853,222	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	23,414,634	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	63,790,150	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	2,189,853	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,122,946	0	0	0	38.00
39.00 Payroll taxes payable	321,467	0	0	0	39.00
40.00 Notes and loans payable (short term)	1,361,449	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	43,890	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	5,039,605	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	28,055,019	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	0	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	28,055,019	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	33,094,624	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	30,695,526	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)	30,695,526	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	63,790,150	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet G-1

Date/Time Prepared:
11/29/2011 8:53 am

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
1.00 Fund balances at beginning of period		28,535,205		0	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		909,337			2.00
3.00 Total (sum of line 1 and line 2)		29,444,542		0	3.00
4.00 Additions (credit adjustments) (specify)	0		0		4.00
5.00 RESTRICTED CONTRIBUTIONS	1,149,763		0		5.00
6.00 UNREALIZED GAINS AND LOSS	95,953		0		6.00
7.00 FOUNDATION ACTIVITY	5,268		0		7.00
8.00	0		0		8.00
9.00	0		0		9.00
10.00 Total additions (sum of line 4-9)		1,250,984		0	10.00
11.00 Subtotal (line 3 plus line 10)		30,695,526		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)		30,695,526		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet G-1

Date/Time Prepared:
11/29/2011 8:53 am

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
	1.00					
2.00			0		0	2.00
3.00		0			0	3.00
4.00						4.00
5.00	0		0			5.00
6.00	0		0			6.00
7.00	0		0			7.00
8.00	0		0			8.00
9.00	0		0			9.00
10.00		0			0	10.00
11.00		0			0	11.00
12.00	0		0			12.00
13.00	0		0			13.00
14.00	0		0			14.00
15.00	0		0			15.00
16.00	0		0			16.00
17.00	0		0			17.00
18.00		0			0	18.00
19.00		0			0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet G-2 Parts

Date/Time Prepared:
11/29/2011 8:53 am

Cost Center Description	Inpatient	Outpatient	Total	
	1.00	2.00	3.00	
PART I - PATIENT REVENUES				
General Inpatient Routine Services				
1.00 Hospital				1.00
2.00 SUBPROVIDER - IPF	2,586,969		2,586,969	2.00
3.00 SUBPROVIDER - IRF				3.00
4.00 SUBPROVIDER				4.00
5.00 Swing bed - SNF				5.00
6.00 Swing bed - NF	0		0	6.00
7.00 SKILLED NURSING FACILITY	150,930		150,930	7.00
8.00 NURSING FACILITY	416,152		416,152	8.00
9.00 OTHER LONG TERM CARE				9.00
10.00 Total general inpatient care services (sum of lines 1-9)	1,658,830		1,658,830	10.00
	4,812,881		4,812,881	
Intensive Care Type Inpatient Hospital Services				
11.00 INTENSIVE CARE UNIT				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)	0		0	16.00
17.00 Total inpatient routine care services (sum of lines 10 and 16)	4,812,881		4,812,881	17.00
18.00 Ancillary services	12,998,842	36,174,153	49,172,995	18.00
19.00 Outpatient services	0	411,211	411,211	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	0	22.00
23.00 AMBULANCE SERVICES				23.00
24.00 CMHC				24.00
24.10 CORF	0	0	0	24.10
25.00 AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00 HOSPICE				26.00
27.00 HOME HEALTH AGENCY	0	754,070	754,070	27.00
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	17,811,723	37,339,434	55,151,157	28.00
PART II - OPERATING EXPENSES				
29.00 Operating expenses (per wkst. A, column 3, line 200)		28,697,802		29.00
30.00 BAD DEBT EXPENSE	869,664			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	869,664		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	0		42.00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		29,567,466		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet G-3

Date/Time Prepared:

11/29/2011 8:53 am

1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1.00	
2.00	Less contractual allowances and discounts on patients' accounts	55,151,157	1.00
3.00	Net patient revenues (line 1 minus line 2)	26,557,391	2.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,593,766	3.00
5.00	Net income from service to patients (line 3 minus line 4)	29,567,466	4.00
		-973,700	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	58,257	6.00
7.00	Income from investments	298,147	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	180,446	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	335,858	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	OTHER REVENUE	6,328	24.01
24.02	GRANT REVENUE	205,146	24.02
24.03	ATHLETIC TRAINING	18,153	24.03
24.04	SUMMIT	63,030	24.04
24.05	OUTREACH SERVICES	13,719	24.05
24.06	PROPERTY TAX REVENUE	692,469	24.06
24.07	LEASED SPACE AND EMPLOYEES	11,484	24.07
24.08	GAIN ON DISPOSAL OF CAPITAL ASSETS	0	24.08
24.09		0	24.09
25.00	Total other income (sum of lines 6-24)	1,883,037	25.00
26.00	Total (line 5 plus line 25)	909,337	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	909,337	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141319 Period: From 06/01/2010 To 05/31/2011 worksheet H
 HHA CCN: 147450 Date/Time Prepared: 11/29/2011 8:53 am
 Home Health Agency I PPS

	Salaries 1.00	Employee Benefits 2.00	Transportation (see instructions) 3.00	Contracted/Purchased Services 4.00	Other Costs 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	97,040	0	0	0	57,533 5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	305,657	0	26,868	0	6.00
7.00	Physical Therapy	0	0	9,069	0	7.00
8.00	Occupational Therapy	0	0	2,778	0	8.00
9.00	Speech Pathology	0	0	601	0	9.00
10.00	Medical Social Services	0	0	292	0	10.00
11.00	Home Health Aide	28,358	0	8,544	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	431,055	0	48,152	0	57,533 24.00

Column, 6 line 24 should agree with the worksheet A, column 7, line 101, or subscript as applicable.
 11/29/2011 8:53 am

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141319
 HHA CCN: 147450
 Period: From 06/01/2010 To 05/31/2011
 Worksheet H
 Date/Time Prepared: 11/29/2011 8:53 am
 Home Health Agency I
 PPS

	Total (sum of cols. 1 thru 5)	Reclassificati on	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
	6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00 Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00 Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00 Transportation	0	0	0	0	0	4.00
5.00 Administrative and General	154,573	0	154,573	-4,728	149,845	5.00
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	332,525	0	332,525	0	332,525	6.00
7.00 Physical Therapy	9,069	0	9,069	0	9,069	7.00
8.00 Occupational Therapy	2,778	0	2,778	0	2,778	8.00
9.00 Speech Pathology	601	0	601	0	601	9.00
10.00 Medical Social Services	292	0	292	0	292	10.00
11.00 Home Health Aide	36,902	0	36,902	0	36,902	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	0	0	0	0	0	23.00
24.00 Total (sum of lines 1-23)	536,740	0	536,740	-4,728	532,012	24.00

Column, 6 line 24 should agree with the worksheet A, column 7, line 101, or subscript as applicable.
 11/29/2011 8:53 am

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 141319

Period:

Worksheet H-1

HHA CCN: 147450

From 06/01/2010

Part I

To 05/31/2011

Date/Time Prepared:

11/29/2011 8:53 am

Home Health Agency I

PPS

	Net Expenses for Cost Allocation (from wkst. H, col. 10)	Capital Related Costs				Transportation	
		Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance			
		1.00	2.00	3.00	4.00		
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				1.00
2.00	Capital Related - Movable Equipment	0		0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	149,845	0	0	0	0	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	332,525	0	0	0	0	6.00
7.00	Physical Therapy	9,069	0	0	0	0	7.00
8.00	Occupational Therapy	2,778	0	0	0	0	8.00
9.00	Speech Pathology	601	0	0	0	0	9.00
10.00	Medical Social Services	292	0	0	0	0	10.00
11.00	Home Health Aide	36,902	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	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	532,012	0	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 141319

Period:

Worksheet H-1

HHA CCN: 147450

From 06/01/2010

Part I

To 05/31/2011

Date/Time Prepared:
11/29/2011 8:53 am

Home Health
Agency I

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		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	149,845	149,845		5.00
HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	332,525	130,381	462,906	6.00
7.00	Physical Therapy	9,069	3,556	12,625	7.00
8.00	Occupational Therapy	2,778	1,089	3,867	8.00
9.00	Speech Pathology	601	236	837	9.00
10.00	Medical Social Services	292	114	406	10.00
11.00	Home Health Aide	36,902	14,469	51,371	11.00
12.00	Supplies (see instructions)	0	0	0	12.00
13.00	Drugs	0	0	0	13.00
14.00	DME	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	17.00
18.00	Clinic	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	19.00
20.00	Day Care Program	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	21.00
22.00	Homemaker Service	0	0	0	22.00
23.00	All Others	0	0	0	23.00
24.00	Total (sum of lines 1-23)	382,167		532,012	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 141319

Period: From 06/01/2010

Worksheet H-1

HHA CCN: 147450

To 05/31/2011

Part II
Date/Time Prepared:
11/29/2011 8:53 am

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	-149,845	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	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	0	24.00
25.00	Cost To Be Allocated (per worksheet H-1, Part I)	0	0	0	0	-149,845	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 141319	Period: From 06/01/2010 To 05/31/2011	Worksheet H-1 Part II Date/Time Prepared: 11/29/2011 8:53 am
HHA CCN: 147450	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	382,167	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	332,525	6.00
7.00	Physical Therapy	9,069	7.00
8.00	Occupational Therapy	2,778	8.00
9.00	Speech Pathology	601	9.00
10.00	Medical Social Services	292	10.00
11.00	Home Health Aide	36,902	11.00
12.00	Supplies (see instructions)	0	12.00
13.00	Drugs	0	13.00
14.00	DME	0	14.00
HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	15.00
16.00	Respiratory Therapy	0	16.00
17.00	Private Duty Nursing	0	17.00
18.00	Clinic	0	18.00
19.00	Health Promotion Activities	0	19.00
20.00	Day Care Program	0	20.00
21.00	Home Delivered Meals Program	0	21.00
22.00	Homemaker Service	0	22.00
23.00	All others	0	23.00
24.00	Total (sum of lines 1-23)	382,167	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	149,845	25.00
26.00	Unit Cost Multiplier	0.392093	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet H-2
Part I
Date/Time Prepared:
11/29/2011 8:53 am

HHA CCN: 147450

Home Health
Agency I

PPS

	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS 4.00	DATA PROCESSING 5.01	
		NEW BLDG & FIXT 1.00	NEW MVBLE EQUIP 2.00			
1.00 Administrative and General	0	10,697	4,514	27,971	94,774	1.00
2.00 Skilled Nursing Care	462,906	0	0	88,104	0	2.00
3.00 Physical Therapy	12,625	0	0	0	0	3.00
4.00 Occupational Therapy	3,867	0	0	0	0	4.00
5.00 Speech Pathology	837	0	0	0	0	5.00
6.00 Medical Social Services	406	0	0	0	0	6.00
7.00 Home Health Aide	51,371	0	0	8,174	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	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	532,012	10,697	4,514	124,249	94,774	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: 141319

Period: From 06/01/2010

Worksheet H-2

HHA CCN: 147450

To 05/31/2011

Part I
Date/Time Prepared: 11/29/2011 8:53 am

Home Health Agency I

PPS

	PURCHASING RECEIVING AND STORES 5.02	ADMITTING 5.03	CASHIERING/ACCOUNTS RECEIVABLE 5.04	Subtotal 5A.04	OTHER ADMINISTRATIVE AND GENERAL 5.05	
1.00 Administrative and General	1,717	0	6,509	146,182	13,467	1.00
2.00 Skilled Nursing Care	0	0	0	551,010	50,762	2.00
3.00 Physical Therapy	0	0	0	12,625	1,163	3.00
4.00 Occupational Therapy	0	0	0	3,867	356	4.00
5.00 Speech Pathology	0	0	0	837	77	5.00
6.00 Medical Social Services	0	0	0	406	37	6.00
7.00 Home Health Aide	0	0	0	59,545	5,485	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	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	1,717	0	6,509	774,472	71,347	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: 141319

Period:
From 06/01/2010
To 05/31/2011

Worksheet H-2
Part I
Date/Time Prepared:
11/29/2011 8:53 am

HHA CCN: 147450

Home Health
Agency I

PPS

	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
	7.00	8.00	9.00	10.00	11.00	
1.00 Administrative and General	17,432	0	3,989	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	17,432	0	3,989	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141319

Period:

Worksheet H-2

HHA CCN: 147450

From 06/01/2010
To 05/31/2011

Part I
Date/Time Prepared:
11/29/2011 8:53 am

Home Health
Agency I

PPS

	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	13.00	14.00	15.00	16.00	17.00	
1.00 Administrative and General	16,034	0	0	9,007	8,289	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	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	16,034	0	0	9,007	8,289	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: 141319

Period: From 06/01/2010

Worksheet H-2

HHA CCN: 147450

To 05/31/2011

Part I

Date/Time Prepared: 11/29/2011 8:53 am

Home Health Agency I

PPS

	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
	24.00	25.00	26.00	27.00	28.00	
1.00 Administrative and General	214,400	0	214,400			1.00
2.00 Skilled Nursing Care	601,772	0	601,772	188,029	789,801	2.00
3.00 Physical Therapy	13,788	0	13,788	4,308	18,096	3.00
4.00 Occupational Therapy	4,223	0	4,223	1,320	5,543	4.00
5.00 Speech Pathology	914	0	914	286	1,200	5.00
6.00 Medical Social Services	443	0	443	138	581	6.00
7.00 Home Health Aide	65,030	0	65,030	20,319	85,349	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	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	900,570	0	900,570	214,400	900,570	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.				0.312459		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: 141319
HHA CCN: 147450

Period:
From 06/01/2010
To 05/31/2011

Worksheet H-2
Part II
Date/Time Prepared:
11/29/2011 8:53 am

Home Health
Agency I

PPS

	CAPITAL RELATED COSTS					
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COST)	
	1.00	2.00	4.00	5.01	5.02	
1.00 Administrative and General	1,250	4,417	97,040	5,450	30,198	1.00
2.00 Skilled Nursing Care	0	0	305,657	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	28,358	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	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	1,250	4,417	431,055	5,450	30,198	20.00
21.00 Total cost to be allocated	10,697	4,514	124,249	94,774	1,717	21.00
22.00 Unit cost multiplier	8.557600	1.021961	0.288244	17.389725	0.056858	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 141319	Period: From 06/01/2010 To 05/31/2011	Worksheet H-2 Part II
	HHA CCN: 147450		Date/Time Prepared: 11/29/2011 8:53 am

		ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	7.00	
1.00	Administrative and General	0	754,070	0	146,182	1,250	1.00
2.00	Skilled Nursing Care	0	0	0	551,010	0	2.00
3.00	Physical Therapy	0	0	0	12,625	0	3.00
4.00	Occupational Therapy	0	0	0	3,867	0	4.00
5.00	Speech Pathology	0	0	0	837	0	5.00
6.00	Medical Social Services	0	0	0	406	0	6.00
7.00	Home Health Aide	0	0	0	59,545	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	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	754,070	0	774,472	1,250	20.00
21.00	Total cost to be allocated	0	6,509	0	71,347	17,432	21.00
22.00	Unit cost multiplier	0.000000	0.008632	0	0.092123	13.945600	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141319
HHA CCN: 147450

Period:
From 06/01/2010
To 05/31/2011

Worksheet H-2
Part II
Date/Time Prepared:
11/29/2011 8:53 am
PPS

		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	Home Health Agency I CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	
		8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	3,325	0	0	858	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	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	3,325	0	0	858	20.00
21.00	Total cost to be allocated	0	3,989	0	0	16,034	21.00
22.00	Unit cost multiplier	0.000000	1.199699	0.000000	0.000000	18.687646	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141319
HHA CCN: 147450

Period:
From 06/01/2010
To 05/31/2011

Worksheet H-2
Part II
Date/Time Prepared:
11/29/2011 8:53 am

Home Health
Agency I

PPS

	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	SOCIAL SERVICE (TIME SPENT)	
	14.00	15.00	16.00	17.00	
1.00 Administrative and General	0	0	754,070	2,075	1.00
2.00 Skilled Nursing Care	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	9.00
10.00 DME	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	18.00
19.00 All Others	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	754,070	2,075	20.00
21.00 Total cost to be allocated	0	0	9,007	8,289	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.011945	3.994699	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141319
HHA CCN: 147450

Period:
From 06/01/2010
To 05/31/2011

Worksheet H-3
Parts I-II
Date/Time Prepared:
11/29/2011 8:53 am

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	789,801		789,801	4,604	1.00
2.00	Physical Therapy	3.00	18,096	116,031	134,127	1,554	2.00
3.00	Occupational Therapy	4.00	5,543	42,804	48,347	476	3.00
4.00	Speech Pathology	5.00	1,200	12,155	13,355	103	4.00
5.00	Medical Social Services	6.00	581		581	50	5.00
6.00	Home Health Aide	7.00	85,349		85,349	1,464	6.00
7.00	Total (sum of lines 1-6)		900,570	170,990	1,071,560	8,251	7.00

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

Limitation Cost Computation

8.00	Skilled Nursing Care		19340	0	0	8.00
9.00	Physical Therapy		19340	0	0	9.00
10.00	Occupational Therapy		19340	0	0	10.00
11.00	Speech Pathology		19340	0	0	11.00
12.00	Medical Social Services		19340	0	0	12.00
13.00	Home Health Aide		19340	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	241	241	8,000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00

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

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

1.00	Physical Therapy	66.00	0.466091	248,944	116,031	1.00
2.00	Occupational Therapy	67.00	0.523209	81,810	42,804	2.00
3.00	Speech Pathology	68.00	0.825774	14,720	12,155	3.00
4.00	Cost of Medical Supplies	71.00	0.030176	8,000	241	4.00
5.00	Cost of Drugs	73.00	0.293313	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141319
 HHA CCN: 147450
 Period: From 06/01/2010 To 05/31/2011
 Worksheet H-3
 Parts I-II
 Date/Time Prepared: 11/29/2011 8:53 am
 PPS

Cost Center Description		Average Cost Per Visit (col. 3 ÷ col. 4)	Program Visits				
			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	171.55	1,266	2,409		1.00	
2.00	Physical Therapy	86.31	620	647		2.00	
3.00	Occupational Therapy	101.57	217	214		3.00	
4.00	Speech Pathology	129.66	65	5		4.00	
5.00	Medical Social Services	11.62	16	33		5.00	
6.00	Home Health Aide	58.30	350	1,039		6.00	
7.00	Total (sum of lines 1-6)		2,534	4,347		7.00	
Cost Center Description		5.00	6.00	7.00	8.00	9.00	
Limitation Cost Computation							
8.00	Skilled Nursing Care					8.00	
9.00	Physical Therapy					9.00	
10.00	Occupational Therapy					10.00	
11.00	Speech Pathology					11.00	
12.00	Medical Social Services					12.00	
13.00	Home Health Aide					13.00	
14.00	Total (sum of lines 8-13)					14.00	
Cost Center Description		Ratio (col. 3 ÷ col. 4)	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00		
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0.030125	1,470	4,042	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: 141319 HHA CCN: 147450		Period: From 06/01/2010 To 05/31/2011		Worksheet H-3 Parts I-II Date/Time Prepared: 11/29/2011 8:53 am	
				Title XVIII		Home Health Agency I	
				PPS			
Cost Center Description		Cost of Services				Total Program Cost (sum of cols. 9-10)	
		Part A	Part B		12.00		
			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	217,182	413,264		630,446		1.00
2.00	Physical Therapy	53,512	55,843		109,355		2.00
3.00	Occupational Therapy	22,041	21,736		43,777		3.00
4.00	Speech Pathology	8,428	648		9,076		4.00
5.00	Medical Social Services	186	383		569		5.00
6.00	Home Health Aide	20,405	60,574		80,979		6.00
7.00	Total (sum of lines 1-6)	321,754	552,448		874,202		7.00
Cost Center Description							
		10.00	11.00	12.00			
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00
Cost Center Description		Cost of Services					
		Part A	Part B				
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
		9.00	10.00	11.00			
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	44	122	0			15.00
16.00	Cost of Drugs	0	0	0			16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 141319	Period: From 06/01/2010 To 05/31/2011	Worksheet H-4 Part I-II Date/Time Prepared: 11/29/2011 8:53 am
	HHA CCN: 147450	Title XVIII	Home Health Agency I PPS

	Part A	Part B			
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	1.00	2.00	3.00		
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES					
Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	330,581	519,848	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)	330,581	519,848	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	330,581	519,848	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		300,097	446,843	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	1,184	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		2,887	10,211	13.00
14.00	Total PPS Reimbursement - PEP Episodes		28,311	58,199	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	958	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)		331,295	517,395	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		331,295	517,395	24.00
25.00	Coinsurance billed to program patients (from your records)			0	25.00
26.00	Net cost (line 24 minus line 25)		331,295	517,395	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)		331,295	517,395	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)		331,295	517,395	31.00
32.00	Interim payments (see instructions)		331,295	517,395	32.00
33.00	Tentative settlement (for contractor use only)		0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 141319	Period: From 06/01/2010 To 05/31/2011	Worksheet H-5	
		HHA CCN: 147450	Date/Time Prepared: 11/29/2011 8:53 am		
		Home Health Agency I		PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
1.00	Total interim payments paid to provider	1.00	2.00	3.00	4.00
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		331,295		517,395
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)		0		0
Program to Provider					
3.01			0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50			0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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)		331,295		517,395
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)				
Program to Provider					
5.01			0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50			0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		331,295		517,395
				Contractor Number	Date (Mo/Day/Yr)
				1.00	2.00
8.00	Name of Contractor	0			