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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140160	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/24/2012 6:58 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/24/2012 Time: 6:58 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [0] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 04
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	93,271	-37,217	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	6,953	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	100,224	-37,217	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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FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140160	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/24/2012 6:58 pm

PART I - COST REPORT STATUS

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   (3) Settled with Audit
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7. Contractor No.
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CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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Encryption Information

ECR: Date: 5/24/2012 Time: 6:58 pm
V3.2GbpnVoDAO8Yq:iy.FuLQDjFoi0
YJm1b0vWtZfl1uEE2H:4hANuoUV.WH
u.z00wALUJ0p0Kt5

PI: Date: 5/24/2012 Time: 6:58 pm
XnfOj:tsqrPcQ3eFa7ItKXBq07rpT0
yw9in0FgS6:y5P9IS2aEKhqHgATPKF
DcNrVsPcke0AoMLc

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

_____
Title

_____
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	93,271	-37,217	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	6,953	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	100,224	-37,217	0	0	200.00

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2012 11:36 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1405 WEST STEPHENSON STREET	PO Box:			1.00
2.00	City: FREEPORT	State: IL	Zip Code: 64032	County: STEPHENSON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	FHN MEMORIAL HOSPITAL	140160	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF						N	N	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF	FHN MEMORIAL - SNF	145531	99914		09/13/1985	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	FHN MEMORIAL - HOSPICE	141560	99914		08/12/1993				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of State Medicaid paid days	Out-of State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	2,840	548	3	6	0	0	24.00
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0	0	0	0	0	0	25.00

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

		Beginning: 1.00	Ending: 2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	1		37.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140160	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/24/2012 11:36 am

		Beginning:	Ending:	
		1.00	2.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	01/01/2011	12/31/2011	38.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	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)		0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2012 11:36 am

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2012 11:36 am

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

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

		V	XIX	
		1.00	2.00	
	Title V or XIX Inpatient Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	2.00	
	Miscellaneous Cost Reporting Information			
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.	N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	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.	2,000,000	22,000,000	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	Y	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.	N		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2012 11:36 am

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2012 11:36 am

			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)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
			Part A		
		Description	Y/N	Date	
		0	1.00	2.00	
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	05/11/2012	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part II Date/Time Prepared: 5/24/2012 11:36 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part II Date/Time Prepared: 5/24/2012 11:36 am

		Part B		
		Y/N	Date	
		3.00	4.00	
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/11/2012	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: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I Date/Time Prepared: 5/24/2012 11:36 am

	Cost Center Description	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours		
		1.00	2.00	3.00	4.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	92	33,580	0.00		1.00
2.00	HMO						2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		92	33,580	0.00		7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	0.00		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00					13.00
14.00	Total (see instructions)		100	36,500	0.00		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	0	6,570			19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		100				27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2012 11:36 am

	Cost Center Description	I/P Days / O/P Visits / Trips					
		Title V	Title XVIII	Title XIX	Total All Patients		
		5.00	6.00	7.00	8.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	8,469	2,324	15,664		1.00
2.00	HMO		1,997	0			2.00
3.00	HMO IPF		0	0			3.00
4.00	HMO IRF		0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	8,469	2,324	15,664		7.00
8.00	INTENSIVE CARE UNIT	0	938	212	1,576		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		761	1,000		13.00
14.00	Total (see instructions)	0	9,407	3,297	18,240		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	2,491	0	3,593		19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE		0	0	0		24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)						27.00
28.00	Observation Bed Days	0		0	2,237		28.00
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)			100	146		32.00
33.00	LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2012 11:36 am

	Cost Center Description	Full Time Equivalents			Discharges		
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
		9.00	10.00	11.00	12.00	13.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	2,290	1.00
2.00	HMO					480	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	531.07	0.00	0	2,290	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	25.94	0.00			19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00	18.66	0.00			24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00	575.67	0.00			27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2012 11:36 am

	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)	868	5,154		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)	868	5,154		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF				16.00
17.00	SUBPROVIDER - IRF				17.00
18.00	SUBPROVIDER				18.00
19.00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE				21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00	HOSPICE				24.00
25.00	CMHC - CMHC				25.00
26.00	RURAL HEALTH CLINIC				26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days - IRF				31.00
32.00	Labor & delivery days (see instructions)				32.00
33.00	LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part II Date/Time Prepared: 5/24/2012 11:36 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
		1.00	2.00	3.00	4.00	5.00	
	PART II - WAGE DATA						
	SALARIES						
1.00	Total salaries (see instructions)	200.00	30,579,544	0	30,579,544	1,128,388.00	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	3.00
4.00	Physician-Part A		0	0	0	0.00	4.00
4.01	Physicians - Part A - direct teaching		0	0	0	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	7.00
7.01	Contracted interns and residents (in approved programs)		0	0	0	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	8.00
9.00	SNF	44.00	1,133,237	0	1,133,237	53,962.00	9.00
10.00	Excluded area salaries (see instructions)		913,465	60,815	974,280	43,010.00	10.00
	OTHER WAGES & RELATED COSTS						
11.00	Contract labor (see instructions)		558,369	0	558,369	8,684.00	11.00
12.00	Management and administrative services		0	0	0	0.00	12.00
13.00	Contract labor: physician-Part A		26,199	0	26,199	497.00	13.00
14.00	Home office salaries & wage-related costs		4,308,111	0	4,308,111	140,348.00	14.00
15.00	Home office: physician Part A		0	0	0	0.00	15.00
16.00	Teaching physician salaries (see instructions)		0	0	0	0.00	16.00
	WAGE-RELATED COSTS						
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		8,186,810	0	8,186,810		17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25		0	0	0		18.00
19.00	Excluded areas		706,327	0	706,327		19.00
20.00	Non-physician anesthetist Part A		0	0	0		20.00
21.00	Non-physician anesthetist Part B		0	0	0		21.00
22.00	Physician Part A		0	0	0		22.00
23.00	Physician Part B		0	0	0		23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0		24.00
25.00	Interns & residents (in an approved program)		0	0	0		25.00
	OVERHEAD COSTS - DIRECT SALARIES						
26.00	Employee Benefits	4.00	0	0	0	0.00	26.00
27.00	Administrative & General	5.00	2,214,058	-17,655	2,196,403	102,215.00	27.00
28.00	Administrative & General under contract (see inst.)		123,262	0	123,262	822.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	29.00
30.00	Operation of Plant	7.00	211,114	0	211,114	14,047.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,688,435	0	1,688,435	91,487.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	34.00
35.00	Dietary under contract (see instructions)		1,845,736	0	1,845,736	71,977.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	37.00
38.00	Nursing Administration	13.00	590,283	0	590,283	15,445.00	38.00
39.00	Central Services and Supply	14.00	70,228	0	70,228	6,084.00	39.00
40.00	Pharmacy	15.00	1,120,727	0	1,120,727	35,162.00	40.00
41.00	Medical Records & Medical Records Library	16.00	1,013,909	0	1,013,909	47,616.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part II | Date/Time Prepared: 5/24/2012 11:36 am

		Average Hourly Wage (col. 4 ÷ col. 5)		
		6.00		
	PART II - WAGE DATA			
	SALARIES			
1.00	Total salaries (see instructions)	27.10		1.00
2.00	Non-physician anesthetist Part A	0.00		2.00
3.00	Non-physician anesthetist Part B	0.00		3.00
4.00	Physician-Part A	0.00		4.00
4.01	Physicians - Part A - direct teaching	0.00		4.01
5.00	Physician-Part B	0.00		5.00
6.00	Non-physician-Part B	0.00		6.00
7.00	Interns & residents (in an approved program)	0.00		7.00
7.01	Contracted interns and residents (in approved programs)	0.00		7.01
8.00	Home office personnel	0.00		8.00
9.00	SNF	21.00		9.00
10.00	Excluded area salaries (see instructions)	22.65		10.00
	OTHER WAGES & RELATED COSTS			
11.00	Contract labor (see instructions)	64.30		11.00
12.00	Management and administrative services	0.00		12.00
13.00	Contract labor: physician-Part A	52.71		13.00
14.00	Home office salaries & wage-related costs	30.70		14.00
15.00	Home office: physician Part A	0.00		15.00
16.00	Teaching physician salaries (see instructions)	0.00		16.00
	WAGE-RELATED COSTS			
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24			17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25			18.00
19.00	Excluded areas			19.00
20.00	Non-physician anesthetist Part A			20.00
21.00	Non-physician anesthetist Part B			21.00
22.00	Physician Part A			22.00
23.00	Physician Part B			23.00
24.00	Wage-related costs (RHC/FQHC)			24.00
25.00	Interns & residents (in an approved program)			25.00
	OVERHEAD COSTS - DIRECT SALARIES			
26.00	Employee Benefits	0.00		26.00
27.00	Administrative & General	21.49		27.00
28.00	Administrative & General under contract (see inst.)	149.95		28.00
29.00	Maintenance & Repairs	0.00		29.00
30.00	Operation of Plant	15.03		30.00
31.00	Laundry & Linen Service	0.00		31.00
32.00	Housekeeping	0.00		32.00
33.00	Housekeeping under contract (see instructions)	18.46		33.00
34.00	Dietary	0.00		34.00
35.00	Dietary under contract (see instructions)	25.64		35.00
36.00	Cafeteria	0.00		36.00
37.00	Maintenance of Personnel	0.00		37.00
38.00	Nursing Administration	38.22		38.00
39.00	Central Services and Supply	11.54		39.00
40.00	Pharmacy	31.87		40.00
41.00	Medical Records & Medical Records Library	21.29		41.00
42.00	Social Service	0.00		42.00
43.00	Other General Service	0.00		43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part III Date/Time Prepared: 5/24/2012 11:36 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
		1.00	2.00	3.00	4.00	5.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY						
1.00	Net salaries (see instructions)		34,236,977	0	34,236,977	1,292,674.00	1.00
2.00	Excluded area salaries (see instructions)		2,046,702	60,815	2,107,517	96,972.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		32,190,275	-60,815	32,129,460	1,195,702.00	3.00
4.00	Subtotal other wages & related costs (see inst.)		4,892,679	0	4,892,679	149,529.00	4.00
5.00	Subtotal wage-related costs (see inst.)		8,186,810	0	8,186,810	0.00	5.00
6.00	Total (sum of lines 3 thru 5)		45,269,764	-60,815	45,208,949	1,345,231.00	6.00
7.00	Total overhead cost (see instructions)		8,877,752	-17,655	8,860,097	384,855.00	7.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part III Date/Time Prepared: 5/24/2012 11:36 am

		Average Hourly Wage (col. 4 ÷ col. 5)		
		6.00		
	PART III - HOSPITAL WAGE INDEX SUMMARY			
1.00	Net salaries (see instructions)	26.49		1.00
2.00	Excluded area salaries (see instructions)	21.73		2.00
3.00	Subtotal salaries (line 1 minus line 2)	26.87		3.00
4.00	Subtotal other wages & related costs (see inst.)	32.72		4.00
5.00	Subtotal wage-related costs (see inst.)	25.48		5.00
6.00	Total (sum of lines 3 thru 5)	33.61		6.00
7.00	Total overhead cost (see instructions)	23.02		7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part IV Date/Time Prepared: 5/24/2012 11:36 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	733,288	3.00
4.00	Prior Year Pension Service Cost	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	5,313,798	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	218,245	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	45,879	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	102,890	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	222,760	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,194,197	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	62,081	20.00
	OTHER		
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,893,138	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part V Date/Time Prepared: 5/24/2012 11:36 am

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-7 | Date/Time Prepared: 5/24/2012 11:36 am

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	47	0	47	7.00
8.00		RHL	182	0	182	8.00
9.00		RMX	75	0	75	9.00
10.00		RML	119	0	119	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	44	0	44	15.00
16.00		RVB	50	0	50	16.00
17.00		RVA	91	0	91	17.00
18.00		RHC	55	0	55	18.00
19.00		RHB	201	0	201	19.00
20.00		RHA	537	0	537	20.00
21.00		RMC	67	0	67	21.00
22.00		RMB	90	0	90	22.00
23.00		RMA	340	0	340	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	7	0	7	27.00
28.00		ES1	213	0	213	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	7	0	7	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	3	0	3	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	45	0	45	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	10	0	10	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	20	0	20	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	15	0	15	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	57	0	57	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	18	0	18	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	19	0	19	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	168	0	168	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-7 | Date/Time Prepared: 5/24/2012 11:36 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	4	0	4	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	4	0	4	78.00
199.00		AAA	3	0	3	199.00
200.00	TOTAL		2,491	0	2,491	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99914	99914	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	1,133,237	100.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	1,466,477			207.00

HOSPITAL IDENTIFICATION DATA	Provider CCN: 140160 Component CCN: 141560	Period: From 01/01/2011 To 12/31/2011	Worksheet S-9 Parts I & II Date/Time Prepared: 5/24/2012 11:36 am

Hospice I

		Unduplicated Days					
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ENROLLMENT DAYS						
1.00	Continuous Home Care	0	0	0	0	0	1.00
2.00	Routine Home Care	13,368	484	0	0	712	2.00
3.00	Inpatient Respite Care	16	0	0	0	0	3.00
4.00	General Inpatient Care	17	0	0	0	0	4.00
5.00	Total Hospice Days	13,401	484	0	0	712	5.00
	Part II - CENSUS DATA						
6.00	Number of Patients Receiving Hospice Care	216	10	0	0	28	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00			7.00
8.00	Average Length of Stay (line 5/line 6)	62.04	48.40	0.00	0.00	25.43	8.00
9.00	Unduplicated Census Count	216	10	0	0	28	9.00

HOSPITAL IDENTIFICATION DATA	Provider CCN: 140160 Component CCN: 141560	Period: From 01/01/2011 To 12/31/2011	Worksheet S-9 Parts I & II Date/Time Prepared: 5/24/2012 11:36 am

Hospice I

		Unduplicated Days Total (sum of cols. 1, 2 & 5)	
		6.00	
	PART I - ENROLLMENT DAYS		
1.00	Continuous Home Care	0	1.00
2.00	Routine Home Care	14,564	2.00
3.00	Inpatient Respite Care	16	3.00
4.00	General Inpatient Care	17	4.00
5.00	Total Hospice Days	14,597	5.00
	Part II - CENSUS DATA		
6.00	Number of Patients Receiving Hospice Care	254	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare		7.00
8.00	Average Length of Stay (line 5/line 6)	57.47	8.00
9.00	Unduplicated Census Count	254	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-10 | Date/Time Prepared: 5/24/2012 11:36 am

		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)	0.325401	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,928,743	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	3,913,055	5.00
6.00	Medicaid charges	40,746,538	6.00
7.00	Medicaid cost (line 1 times line 6)	13,258,964	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)	3,417,166	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,417,166	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	7,617,286	0	7,617,286	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,478,672	0	2,478,672	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,478,672	0	2,478,672	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	9,808,984	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	572,705	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	9,236,279	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	3,005,494	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	5,484,166	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	8,901,332	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A | Date/Time Prepared: 5/24/2012 11:36 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		0	0	1,825,191	1,825,191	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		4,782,324	4,782,324	-1,817,369	2,964,955	2.00
4.00	EMPLOYEE BENEFITS	0	6,096,184	6,096,184	0	6,096,184	4.00
5.00	ADMINISTRATIVE & GENERAL	2,214,058	16,518,605	18,732,663	-29,996	18,702,667	5.00
7.00	OPERATION OF PLANT	211,114	3,178,540	3,389,654	0	3,389,654	7.00
8.00	LAUNDRY & LINEN SERVICE	0	574,778	574,778	0	574,778	8.00
9.00	HOUSEKEEPING	0	1,840,851	1,840,851	0	1,840,851	9.00
10.00	DIETARY	0	2,562,623	2,562,623	-1,255,056	1,307,567	10.00
11.00	CAFETERIA	0	0	0	1,255,056	1,255,056	11.00
13.00	NURSING ADMINISTRATION	590,283	72,880	663,163	0	663,163	13.00
14.00	CENTRAL SERVICES & SUPPLY	70,228	1,319,393	1,389,621	-446,443	943,178	14.00
15.00	PHARMACY	1,120,727	3,793,191	4,913,918	-3,221,190	1,692,728	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,013,909	588,428	1,602,337	0	1,602,337	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	8,334,931	3,048,012	11,382,943	-49,405	11,333,538	30.00
31.00	INTENSIVE CARE UNIT	1,268,083	475,029	1,743,112	0	1,743,112	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	1,133,237	175,786	1,309,023	0	1,309,023	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,742,194	4,486,175	6,228,369	0	6,228,369	50.00
50.01	GI LAB	954,191	780,310	1,734,501	0	1,734,501	50.01
50.02	AMBULATORY CARE UNIT	1,021,057	262,285	1,283,342	0	1,283,342	50.02
51.00	RECOVERY ROOM	511,141	58,518	569,659	0	569,659	51.00
53.00	ANESTHESIOLOGY	0	511,146	511,146	0	511,146	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,859,427	5,262,271	7,121,698	0	7,121,698	54.00
60.00	LABORATORY	1,400,015	2,968,910	4,368,925	0	4,368,925	60.00
65.00	RESPIRATORY THERAPY	716,858	430,878	1,147,736	0	1,147,736	65.00
66.00	PHYSICAL THERAPY	2,034,214	454,575	2,488,789	0	2,488,789	66.00
69.00	ELECTROCARDIOLOGY	165,460	136,062	301,522	0	301,522	69.00
69.01	CATH LAB	477,532	1,273,039	1,750,571	0	1,750,571	69.01
70.00	ELECTROENCEPHALOGRAPHY	102,379	23,072	125,451	0	125,451	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	446,443	446,443	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	3,221,190	3,221,190	73.00
76.00	DIABETIC EDUCATION	1,275	114,151	115,426	0	115,426	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	509,123	509,123	0	509,123	90.00
91.00	EMERGENCY	2,723,766	5,117,248	7,841,014	0	7,841,014	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE		7,822	7,822	-7,822	0	113.00
116.00	HOSPICE	889,210	949,120	1,838,330	0	1,838,330	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	30,555,289	68,371,329	98,926,618	-79,401	98,847,217	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	24,255	118,208	142,463	0	142,463	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	NA VOLUNTEER SERVICES	0	0	0	29,996	29,996	192.03
192.04	SMART STEPS	0	0	0	0	0	192.04
192.05	RESPITE CARE	0	0	0	49,405	49,405	192.05
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
200.00	TOTAL (SUM OF LINES 118-199)	30,579,544	68,489,537	99,069,081	0	99,069,081	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A | Date/Time Prepared: 5/24/2012 11:36 am

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-7,822	1,817,369		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-3,249	2,961,706		2.00
4.00	EMPLOYEE BENEFITS	0	6,096,184		4.00
5.00	ADMINISTRATIVE & GENERAL	-1,608,052	17,094,615		5.00
7.00	OPERATION OF PLANT	0	3,389,654		7.00
8.00	LAUNDRY & LINEN SERVICE	0	574,778		8.00
9.00	HOUSEKEEPING	0	1,840,851		9.00
10.00	DIETARY	-477,032	830,535		10.00
11.00	CAFETERIA	-7,010	1,248,046		11.00
13.00	NURSING ADMINISTRATION	0	663,163		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	943,178		14.00
15.00	PHARMACY	0	1,692,728		15.00
16.00	MEDICAL RECORDS & LIBRARY	-19,517	1,582,820		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-1,557,757	9,775,781		30.00
31.00	INTENSIVE CARE UNIT	-293,795	1,449,317		31.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	-2,500	1,306,523		44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	6,228,369		50.00
50.01	GI LAB	0	1,734,501		50.01
50.02	AMBULATORY CARE UNIT	0	1,283,342		50.02
51.00	RECOVERY ROOM	0	569,659		51.00
53.00	ANESTHESIOLOGY	-323,700	187,446		53.00
54.00	RADIOLOGY-DIAGNOSTIC	-2,265,561	4,856,137		54.00
60.00	LABORATORY	-552,116	3,816,809		60.00
65.00	RESPIRATORY THERAPY	-64,709	1,083,027		65.00
66.00	PHYSICAL THERAPY	-6,657	2,482,132		66.00
69.00	ELECTROCARDIOLOGY	-84,384	217,138		69.00
69.01	CATH LAB	-36,000	1,714,571		69.01
70.00	ELECTROENCEPHALOGRAPHY	0	125,451		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	446,443		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	3,221,190		73.00
76.00	DIABETIC EDUCATION	-2,150	113,276		76.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	509,123		90.00
91.00	EMERGENCY	-4,316,165	3,524,849		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	0	0		113.00
116.00	HOSPICE	-10,000	1,828,330		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-11,638,176	87,209,041		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	142,463		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	JANE ADDAMS BLDG	0	0		192.01
192.02	SENIOR PROGRAM	0	0		192.02
192.03	NA VOLUNTEER SERVICES	0	29,996		192.03
192.04	SMART STEPS	0	0		192.04
192.05	RESPITE CARE	0	49,405		192.05
193.00	NONPAID WORKERS	0	0		193.00
200.00	TOTAL (SUM OF LINES 118-199)	-11,638,176	87,430,905		200.00

RECLASSIFICATIONS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-6 | Date/Time Prepared: 5/24/2012 11:36 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CHARGEABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	446,443	1.00
	TOTALS		0	446,443	
	B - CHARGEABLE DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,221,190	1.00
	TOTALS		0	3,221,190	
	C - SHARED DIETARY EXPENSES				
1.00	CAFETERIA	11.00	0	1,255,056	1.00
	TOTALS		0	1,255,056	
	D - RESPITE CARE (B)				
1.00	RESPITE CARE	192.05	43,160	6,245	1.00
	TOTALS		43,160	6,245	
	E - NON PATIENT VOLUNTEER ADMIN				
1.00	NA VOLUNTEER SERVICES	192.03	17,655	12,341	1.00
	TOTALS		17,655	12,341	
	F - INTEREST EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	7,822	1.00
	TOTALS		0	7,822	
	G - BUILDING DEPRECIATION				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,817,369	1.00
	TOTALS		0	1,817,369	
500.00	Grand Total: Increases		60,815	6,766,466	500.00

RECLASSIFICATIONS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-6 | Date/Time Prepared: 5/24/2012 11:36 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CHARGEABLE SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	446,443	0		1.00
	TOTALS		0	446,443			
	B - CHARGEABLE DRUGS						
1.00	PHARMACY	15.00	0	3,221,190	0		1.00
	TOTALS		0	3,221,190			
	C - SHARED DIETARY EXPENSES						
1.00	DIETARY	10.00	0	1,255,056	0		1.00
	TOTALS		0	1,255,056			
	D - RESPITE CARE (B)						
1.00	ADULTS & PEDIATRICS	30.00	43,160	6,245	0		1.00
	TOTALS		43,160	6,245			
	E - NON PATIENT VOLUNTEER ADMIN						
1.00	ADMINISTRATIVE & GENERAL	5.00	17,655	12,341	0		1.00
	TOTALS		17,655	12,341			
	F - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	7,822	11		1.00
	TOTALS		0	7,822			
	G - BUILDING DEPRECIATION						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,817,369	9		1.00
	TOTALS		0	1,817,369			
500.00	Grand Total: Decreases		60,815	6,766,466			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 5/24/2012 11:36 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	945,058	0	0	0	113	1.00
2.00	Land Improvements	1,358,213	710,953	0	710,953	219,731	2.00
3.00	Buildings and Fixtures	44,978,992	2,568,324	0	2,568,324	420	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,436,104	54,109	0	54,109	142,118	5.00
6.00	Movable Equipment	24,042,336	2,092,246	0	2,092,246	634,447	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	72,760,703	5,425,632	0	5,425,632	996,829	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	72,760,703	5,425,632	0	5,425,632	996,829	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	0	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4,782,324	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,782,324	0	0	0	0	3.00

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	51,689,371	0	51,689,371	0.669642	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	25,500,135	0	25,500,135	0.330358	0	2.00
3.00	Total (sum of lines 1-2)	77,189,506	0	77,189,506	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 5/24/2012 11:36 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	944,945	0				1.00
2.00	Land Improvements	1,849,435	0				2.00
3.00	Buildings and Fixtures	47,546,896	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	1,348,095	0				5.00
6.00	Movable Equipment	25,500,135	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	77,189,506	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	77,189,506	0				10.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	4,782,324				2.00
3.00	Total (sum of lines 1-2)	0	4,782,324				3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,817,369	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,964,955	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,782,324	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 5/24/2012 11:36 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,817,369	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-3,249	0	0	0	2,961,706	2.00
3.00	Total (sum of lines 1-2)	-3,249	0	0	0	4,779,075	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8 | Date/Time Prepared: 5/24/2012 11:36 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		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)		0		0.00	7.00
8.00	Television and radio service (chapter 21)		0		0.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-9,490,213			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	-1,380,069			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests		0		0.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts		0		0.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0		0.00	32.00
33.00	INVST INCOME-NEW BLDGS AND FIXTURES	A	-7,822	NEW CAP REL COSTS-BLDG & FIXT	1.00	33.00
33.01	TRADE, QUANTITY AND TIME DISCOUNTS	B	-14,472	ADMINISTRATIVE & GENERAL	5.00	33.01
33.02	CAFETERIA--EMPLOYEES AND GUESTS	B	-437,751	DIETARY	10.00	33.02
33.03			0		0.00	33.03
33.04	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-19,517	MEDICAL RECORDS & LIBRARY	16.00	33.04
33.05	VENDING MACHINES	B	-7,010	CAFETERIA	11.00	33.05
33.06	DIETARY REVENUE	B	-10,332	DIETARY	10.00	33.06
33.07	PHYSICIAN COLLECTIONS EXPENSES	A	-123,341	ADMINISTRATIVE & GENERAL	5.00	33.07
33.08	DIETARY CONSULTING	B	-150	DIETARY	10.00	33.08
33.09	TELEPHONE CAPITAL COSTS	A	-10,831	ADMINISTRATIVE & GENERAL	5.00	33.09
33.10	TV CAPITAL COSTS	A	-8,526	ADMINISTRATIVE & GENERAL	5.00	33.10
33.11	ASSOC LOBBYING FEES	A	-41,997	ADMINISTRATIVE & GENERAL	5.00	33.11
33.12	MEALS ON WHEELS	B	-28,799	DIETARY	10.00	33.12
33.13	HBP HOSPICE	A	-10,000	HOSPICE	116.00	33.13
33.14	OTHER REVENUE MISC	B	-510	ADMINISTRATIVE & GENERAL	5.00	33.14
33.15	OB MISC INCOME	B	-321	ADULTS & PEDIATRICS	30.00	33.15
33.16	LIFELINE EXPENSE	A	-19,806	ADMINISTRATIVE & GENERAL	5.00	33.16
33.17	OP FINANCE MISC INCOME	B	-8,500	ADMINISTRATIVE & GENERAL	5.00	33.17
33.18			0		0.00	33.18

ADJUSTMENTS TO EXPENSES | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8 | Date/Time Prepared: 5/24/2012 11:36 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
33.19	NONPATIENT DIABETIC REVENUE	B	-2,150	DIABETIC EDUCATION	76.00	33.19
33.20	RADIOLOGY MED RECORD REVENUE	B	-145	RADIOLOGY-DIAGNOSTIC	54.00	33.20
33.21			0		0.00	33.21
33.22	HOSPITALIST BENEFIT EXPENSES	A	-12,008	ADULTS & PEDIATRICS	30.00	33.22
33.23			0		0.00	33.23
33.24	LIFELINE DEPRECIATION	A	-3,249	NEW CAP REL COSTS-MVBLE EQUIP	2.00	33.24
33.25	SPORTS MEDICINE MISC INCOME	B	-657	PHYSICAL THERAPY	66.00	33.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,638,176			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8 | Date/Time Prepared: 5/24/2012 11:36 am

	Cost Center Description	Wkst. A-7 Ref. 5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	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 - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	INVST INCOME-NEW BLDGS AND FIXTURES	11	33.00
33.01	TRADE, QUANTITY AND TIME DISCOUNTS	0	33.01
33.02	CAFETERIA--EMPLOYEES AND GUESTS	0	33.02
33.03		0	33.03
33.04	SALE OF MEDICAL RECORDS & ABSTRACTS	0	33.04
33.05	VENDING MACHINES	0	33.05
33.06	DIETARY REVENUE	0	33.06
33.07	PHYSICIAN COLLECTIONS EXPENSES	0	33.07
33.08	DIETARY CONSULTING	0	33.08
33.09	TELEPHONE CAPITAL COSTS	0	33.09
33.10	TV CAPITAL COSTS	0	33.10
33.11	ASSOC LOBBYING FEES	0	33.11
33.12	MEALS ON WHEELS	0	33.12
33.13	HBP HOSPICE	0	33.13
33.14	OTHER REVENUE MISC	0	33.14
33.15	OB MISC INCOME	0	33.15
33.16	LIFELINE EXPENSE	0	33.16
33.17	OP FINANCE MISC INCOME	0	33.17
33.18		0	33.18
33.19	NONPATIENT DIABETIC REVENUE	0	33.19
33.20	RADIOLOGY MED RECORD REVENUE	0	33.20
33.21		0	33.21
33.22	HOSPITALIST BENEFIT EXPENSES	0	33.22
33.23		0	33.23
33.24	LIFELINE DEPRECIATION	11	33.24
33.25	SPORTS MEDICINE MISC INCOME	0	33.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 140160	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-1 Date/Time Prepared: 5/24/2012 11:36 am

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00		5.00	ADMINISTRATIVE & GENERAL	CORPORATE ALLOCATION	1.00
2.00		0.00			2.00
3.00		0.00			3.00
4.00		0.00			4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

		Symbol (1)	Name	Percentage of Ownership		
		1.00	2.00	3.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00		A	FREEPORT MEMORI	0.00		6.00
7.00				0.00		7.00
8.00				0.00		8.00
9.00				0.00		9.00
10.00				0.00		10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2012 11:36 am

		Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
		4.00	5.00	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		7,850,199	9,230,268	-1,380,069	0		1.00
2.00		0	0	0	0		2.00
3.00		0	0	0	0		3.00
4.00		0	0	0	0		4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	7,850,199	9,230,268	-1,380,069			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

		Related Organization(s) and/or Home Office			
		Name	Percentage of Ownership	Type of Business	
		4.00	5.00	6.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00		FREEPORT HEALTH	100.00	HEALTH CARE PARENT CO	6.00
7.00			0.00		7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:				100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2012 11:36 am

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		30.00	ADULTS & PEDIATRICS	1,545,428	1,545,428	1.00
2.00		31.00	INTENSIVE CARE UNIT	293,795	293,795	2.00
3.00		44.00	SKILLED NURSING FACILITY	2,500	2,500	3.00
4.00		53.00	ANESTHESIOLOGY	323,700	323,700	4.00
5.00		54.00	RADIOLOGY-DIAGNOSTIC	2,265,416	2,265,416	5.00
6.00		60.00	LABORATORY	552,116	552,116	6.00
7.00		65.00	RESPIRATORY THERAPY	64,709	64,709	7.00
8.00		66.00	PHYSICAL THERAPY	6,000	6,000	8.00
9.00		69.00	ELECTROCARDIOLOGY	84,384	84,384	9.00
10.00		69.01	CATH LAB	36,000	36,000	10.00
11.00		91.00	EMERGENCY	4,316,165	4,316,165	11.00
12.00		5.00	ADMINISTRATIVE & GENERAL	26,199	0	12.00
200.00				9,516,412	9,490,213	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2012 11:36 am

		Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
		5.00	6.00	7.00	8.00	9.00	
1.00		0	0	0	0	0	1.00
2.00		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
11.00		0	0	0	0	0	11.00
12.00		26,199	497	159,800	38,183	1,909	12.00
200.00		26,199		159,800	38,183	1,909	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2012 11:36 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
11.00		0	0	0	0	0	11.00
12.00		0	0	0	0	38,183	12.00
200.00		0	0	0	0	38,183	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2012 11:36 am

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	1,545,428		1.00
2.00		0	293,795		2.00
3.00		0	2,500		3.00
4.00		0	323,700		4.00
5.00		0	2,265,416		5.00
6.00		0	552,116		6.00
7.00		0	64,709		7.00
8.00		0	6,000		8.00
9.00		0	84,384		9.00
10.00		0	36,000		10.00
11.00		0	4,316,165		11.00
12.00		0	0		12.00
200.00		0	9,490,213		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I | Date/Time Prepared: 5/24/2012 11:36 am

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,817,369	1,817,369				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,961,706		2,961,706			2.00
4.00	EMPLOYEE BENEFITS	6,096,184	11,624	318	6,108,126		4.00
5.00	ADMINISTRATIVE & GENERAL	17,094,615	306,506	525,542	438,721	18,365,384	5.00
7.00	OPERATION OF PLANT	3,389,654	208,813	30,039	42,169	3,670,675	7.00
8.00	LAUNDRY & LINEN SERVICE	574,778	13,991	0	0	588,769	8.00
9.00	HOUSEKEEPING	1,840,851	30,695	9,079	0	1,880,625	9.00
10.00	DIETARY	830,535	69,092	24,339	0	923,966	10.00
11.00	CAFETERIA	1,248,046	58,968	0	0	1,307,014	11.00
13.00	NURSING ADMINISTRATION	663,163	2,231	97,263	117,906	880,563	13.00
14.00	CENTRAL SERVICES & SUPPLY	943,178	5,335	156	14,028	962,697	14.00
15.00	PHARMACY	1,692,728	14,505	31,359	223,860	1,962,452	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,582,820	26,141	36,352	202,523	1,847,836	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	9,775,781	340,328	294,202	1,656,253	12,066,564	30.00
31.00	INTENSIVE CARE UNIT	1,449,317	25,788	110,217	253,293	1,838,615	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	1,306,523	87,240	12,307	226,358	1,632,428	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	6,228,369	129,268	348,286	347,995	7,053,918	50.00
50.01	GI LAB	1,734,501	41,699	66,420	190,595	2,033,215	50.01
50.02	AMBULATORY CARE UNIT	1,283,342	56,031	28,116	203,951	1,571,440	50.02
51.00	RECOVERY ROOM	569,659	9,969	519	102,098	682,245	51.00
53.00	ANESTHESIOLOGY	187,446	5,143	103,972	0	296,561	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,856,137	104,558	783,494	371,411	6,115,600	54.00
60.00	LABORATORY	3,816,809	52,958	141,166	279,646	4,290,579	60.00
65.00	RESPIRATORY THERAPY	1,083,027	43,509	37,770	143,189	1,307,495	65.00
66.00	PHYSICAL THERAPY	2,482,132	67,810	42,473	406,324	2,998,739	66.00
69.00	ELECTROCARDIOLOGY	217,138	3,916	22,330	33,050	276,434	69.00
69.01	CATH LAB	1,714,571	3,718	99,001	95,385	1,912,675	69.01
70.00	ELECTROENCEPHALOGRAPHY	125,451	7,256	18,121	20,450	171,278	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	446,443	0	0	0	446,443	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,221,190	0	0	0	3,221,190	73.00
76.00	DIABETIC EDUCATION	113,276	2,516	0	255	116,047	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	509,123	0	0	0	509,123	90.00
91.00	EMERGENCY	3,524,849	81,875	93,456	544,059	4,244,239	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	1,828,330	0	5,409	177,615	2,011,354	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	87,209,041	1,811,483	2,961,706	6,091,134	87,186,163	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	142,463	4,740	0	4,845	152,048	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	1,146	0	0	1,146	192.00
192.01	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	NA VOLUNTEER SERVICES	29,996	0	0	3,526	33,522	192.03
192.04	SMART STEPS	0	0	0	0	0	192.04
192.05	RESPITE CARE	49,405	0	0	8,621	58,026	192.05
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	87,430,905	1,817,369	2,961,706	6,108,126	87,430,905	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I | Date/Time Prepared: 5/24/2012 11:36 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	18,365,384					5.00
7.00	OPERATION OF PLANT	976,077	4,646,752				7.00
8.00	LAUNDRY & LINEN SERVICE	156,561	50,380	795,710			8.00
9.00	HOUSEKEEPING	500,081	110,532	0	2,491,238		9.00
10.00	DIETARY	245,694	248,797	0	138,171	1,556,628	10.00
11.00	CAFETERIA	347,551	212,340	0	117,924	0	11.00
13.00	NURSING ADMINISTRATION	234,152	8,032	0	4,461	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	255,993	19,210	0	10,669	0	14.00
15.00	PHARMACY	521,840	52,232	0	29,007	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	491,362	94,133	0	52,277	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,208,676	1,225,509	330,065	680,593	1,242,728	30.00
31.00	INTENSIVE CARE UNIT	488,910	92,861	28,881	51,571	74,115	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	434,082	314,148	34,252	174,464	239,785	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,875,721	465,487	31,605	258,511	0	50.00
50.01	GI LAB	540,656	150,157	48,558	83,391	0	50.01
50.02	AMBULATORY CARE UNIT	417,865	201,764	78,056	112,051	0	50.02
51.00	RECOVERY ROOM	181,417	35,899	20,309	19,937	0	51.00
53.00	ANESTHESIOLOGY	78,859	18,519	0	10,284	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,626,211	376,509	77,990	209,096	0	54.00
60.00	LABORATORY	1,140,916	190,697	0	105,905	0	60.00
65.00	RESPIRATORY THERAPY	347,679	156,672	0	87,009	0	65.00
66.00	PHYSICAL THERAPY	797,401	244,178	7,366	135,606	0	66.00
69.00	ELECTROCARDIOLOGY	73,507	14,101	0	7,831	0	69.00
69.01	CATH LAB	508,603	13,387	0	7,435	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	45,545	26,127	0	14,510	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	118,715	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	856,553	0	0	0	0	73.00
76.00	DIABETIC EDUCATION	30,858	9,059	0	5,031	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	135,382	0	0	0	0	90.00
91.00	EMERGENCY	1,128,594	294,826	138,628	163,733	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	534,843	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	18,300,304	4,625,556	795,710	2,479,467	1,556,628	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	40,431	17,068	0	9,479	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	305	4,128	0	2,292	0	192.00
192.01	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	NA VOLUNTEER SERVICES	8,914	0	0	0	0	192.03
192.04	SMART STEPS	0	0	0	0	0	192.04
192.05	RESPITE CARE	15,430	0	0	0	0	192.05
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	18,365,384	4,646,752	795,710	2,491,238	1,556,628	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I | Date/Time Prepared: 5/24/2012 11:36 am

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
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	1,984,829					11.00
13.00	NURSING ADMINISTRATION	31,011	1,158,219				13.00
14.00	CENTRAL SERVICES & SUPPLY	11,374	0	1,259,943			14.00
15.00	PHARMACY	70,192	0	1,143	2,636,866		15.00
16.00	MEDICAL RECORDS & LIBRARY	95,353	0	0	0	2,580,961	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	609,585	725,940	124,451	7,764	214,613	30.00
31.00	INTENSIVE CARE UNIT	70,285	83,625	20,058	811	32,245	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	105,938	125,085	12,638	1,063	13,741	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	144,330	0	48,429	72,181	386,043	50.00
50.01	GI LAB	71,028	0	105,276	1,151	160,068	50.01
50.02	AMBULATORY CARE UNIT	67,221	0	13,032	222	11,510	50.02
51.00	RECOVERY ROOM	24,187	0	1,464	0	16,846	51.00
53.00	ANESTHESIOLOGY	0	0	53,002	40,330	56,191	53.00
54.00	RADIOLOGY-DIAGNOSTIC	168,377	0	106,322	26,880	463,275	54.00
60.00	LABORATORY	127,293	0	83,914	3,550	305,447	60.00
65.00	RESPIRATORY THERAPY	57,008	0	23,877	10,177	85,260	65.00
66.00	PHYSICAL THERAPY	88,158	0	9,008	59,330	82,091	66.00
69.00	ELECTROCARDIOLOGY	7,799	0	380	0	34,163	69.00
69.01	CATH LAB	29,850	0	2,494	0	106,345	69.01
70.00	ELECTROENCEPHALOGRAPHY	8,124	0	3,195	0	15,012	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	487,457	161	128,313	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	2,263,186	233,302	73.00
76.00	DIABETIC EDUCATION	139	0	0	0	553	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	55,784	3,795	16,114	90.00
91.00	EMERGENCY	188,757	223,569	102,295	5,734	170,728	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	0	0	5,637	140,531	49,101	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,976,009	1,158,219	1,259,856	2,636,866	2,580,961	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,528	0	87	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	NA VOLUNTEER SERVICES	1,300	0	0	0	0	192.03
192.04	SMART STEPS	0	0	0	0	0	192.04
192.05	RESPITE CARE	3,992	0	0	0	0	192.05
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
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)	1,984,829	1,158,219	1,259,943	2,636,866	2,580,961	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I | Date/Time Prepared: 5/24/2012 11:36 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
5.00	ADMINISTRATIVE & GENERAL					5.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
14.00	CENTRAL SERVICES & SUPPLY					14.00
15.00	PHARMACY					15.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	20,436,488	0	20,436,488		30.00
31.00	INTENSIVE CARE UNIT	2,781,977	0	2,781,977		31.00
43.00	NURSERY	0	0	0		43.00
44.00	SKILLED NURSING FACILITY	3,087,624	0	3,087,624		44.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	10,336,225	0	10,336,225		50.00
50.01	GI LAB	3,193,500	0	3,193,500		50.01
50.02	AMBULATORY CARE UNIT	2,473,161	0	2,473,161		50.02
51.00	RECOVERY ROOM	982,304	0	982,304		51.00
53.00	ANESTHESIOLOGY	553,746	0	553,746		53.00
54.00	RADIOLOGY-DIAGNOSTIC	9,170,260	0	9,170,260		54.00
60.00	LABORATORY	6,248,301	0	6,248,301		60.00
65.00	RESPIRATORY THERAPY	2,075,177	0	2,075,177		65.00
66.00	PHYSICAL THERAPY	4,421,877	0	4,421,877		66.00
69.00	ELECTROCARDIOLOGY	414,215	0	414,215		69.00
69.01	CATH LAB	2,580,789	0	2,580,789		69.01
70.00	ELECTROENCEPHALOGRAPHY	283,791	0	283,791		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,181,089	0	1,181,089		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	6,574,231	0	6,574,231		73.00
76.00	DIABETIC EDUCATION	161,687	0	161,687		76.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	720,198	0	720,198		90.00
91.00	EMERGENCY	6,661,103	0	6,661,103		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
	SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE					113.00
116.00	HOSPICE	2,741,466	0	2,741,466		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	87,079,209	0	87,079,209		118.00
	NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	222,641	0	222,641		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	7,871	0	7,871		192.00
192.01	JANE ADDAMS BLDG	0	0	0		192.01
192.02	SENIOR PROGRAM	0	0	0		192.02
192.03	NA VOLUNTEER SERVICES	43,736	0	43,736		192.03
192.04	SMART STEPS	0	0	0		192.04
192.05	RESPITE CARE	77,448	0	77,448		192.05
193.00	NONPAID WORKERS	0	0	0		193.00
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)	87,430,905	0	87,430,905		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II Date/Time Prepared: 5/24/2012 11:36 am

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	0	11,624	318	11,942	11,942	4.00
5.00	ADMINISTRATIVE & GENERAL	0	306,506	525,542	832,048	859	5.00
7.00	OPERATION OF PLANT	0	208,813	30,039	238,852	83	7.00
8.00	LAUNDRY & LINEN SERVICE	0	13,991	0	13,991	0	8.00
9.00	HOUSEKEEPING	0	30,695	9,079	39,774	0	9.00
10.00	DIETARY	0	69,092	24,339	93,431	0	10.00
11.00	CAFETERIA	0	58,968	0	58,968	0	11.00
13.00	NURSING ADMINISTRATION	0	2,231	97,263	99,494	231	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	5,335	156	5,491	27	14.00
15.00	PHARMACY	0	14,505	31,359	45,864	438	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	26,141	36,352	62,493	396	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	340,328	294,202	634,530	3,229	30.00
31.00	INTENSIVE CARE UNIT	0	25,788	110,217	136,005	496	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	87,240	12,307	99,547	443	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	129,268	348,286	477,554	681	50.00
50.01	GI LAB	0	41,699	66,420	108,119	373	50.01
50.02	AMBULATORY CARE UNIT	0	56,031	28,116	84,147	399	50.02
51.00	RECOVERY ROOM	0	9,969	519	10,488	200	51.00
53.00	ANESTHESIOLOGY	0	5,143	103,972	109,115	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	104,558	783,494	888,052	727	54.00
60.00	LABORATORY	0	52,958	141,166	194,124	547	60.00
65.00	RESPIRATORY THERAPY	0	43,509	37,770	81,279	280	65.00
66.00	PHYSICAL THERAPY	0	67,810	42,473	110,283	795	66.00
69.00	ELECTROCARDIOLOGY	0	3,916	22,330	26,246	65	69.00
69.01	CATH LAB	0	3,718	99,001	102,719	187	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	7,256	18,121	25,377	40	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	DIABETIC EDUCATION	0	2,516	0	2,516	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	81,875	93,456	175,331	1,065	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	0	0	5,409	5,409	348	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,811,483	2,961,706	4,773,189	11,909	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,740	0	4,740	9	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	1,146	0	1,146	0	192.00
192.01	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	NA VOLUNTEER SERVICES	0	0	0	0	7	192.03
192.04	SMART STEPS	0	0	0	0	0	192.04
192.05	RESPITE CARE	0	0	0	0	17	192.05
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,817,369	2,961,706	4,779,075	11,942	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II | Date/Time Prepared: 5/24/2012 11:36 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	832,907					5.00
7.00	OPERATION OF PLANT	44,268	283,203				7.00
8.00	LAUNDRY & LINEN SERVICE	7,101	3,070	24,162			8.00
9.00	HOUSEKEEPING	22,680	6,737	0	69,191		9.00
10.00	DIETARY	11,143	15,163	0	3,838	123,575	10.00
11.00	CAFETERIA	15,763	12,941	0	3,275	0	11.00
13.00	NURSING ADMINISTRATION	10,620	490	0	124	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	11,610	1,171	0	296	0	14.00
15.00	PHARMACY	23,667	3,183	0	806	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	22,285	5,737	0	1,452	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	145,496	74,689	10,023	18,903	98,655	30.00
31.00	INTENSIVE CARE UNIT	22,174	5,660	877	1,432	5,884	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	19,687	19,146	1,040	4,846	19,036	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	85,070	28,370	960	7,180	0	50.00
50.01	GI LAB	24,521	9,152	1,474	2,316	0	50.01
50.02	AMBULATORY CARE UNIT	18,952	12,297	2,370	3,112	0	50.02
51.00	RECOVERY ROOM	8,228	2,188	617	554	0	51.00
53.00	ANESTHESIOLOGY	3,577	1,129	0	286	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	73,754	22,947	2,368	5,807	0	54.00
60.00	LABORATORY	51,744	11,622	0	2,941	0	60.00
65.00	RESPIRATORY THERAPY	15,768	9,549	0	2,417	0	65.00
66.00	PHYSICAL THERAPY	36,165	14,882	224	3,766	0	66.00
69.00	ELECTROCARDIOLOGY	3,334	859	0	217	0	69.00
69.01	CATH LAB	23,067	816	0	206	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	2,066	1,592	0	403	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,384	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	38,848	0	0	0	0	73.00
76.00	DIABETIC EDUCATION	1,400	552	0	140	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	6,140	0	0	0	0	90.00
91.00	EMERGENCY	51,186	17,969	4,209	4,547	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	24,257	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	829,955	281,911	24,162	68,864	123,575	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,834	1,040	0	263	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	14	252	0	64	0	192.00
192.01	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	NA VOLUNTEER SERVICES	404	0	0	0	0	192.03
192.04	SMART STEPS	0	0	0	0	0	192.04
192.05	RESPITE CARE	700	0	0	0	0	192.05
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
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)	832,907	283,203	24,162	69,191	123,575	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II Date/Time Prepared: 5/24/2012 11:36 am

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
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	90,947					11.00
13.00	NURSING ADMINISTRATION	1,421	112,380				13.00
14.00	CENTRAL SERVICES & SUPPLY	521	0	19,116			14.00
15.00	PHARMACY	3,216	0	17	77,191		15.00
16.00	MEDICAL RECORDS & LIBRARY	4,369	0	0	0	96,732	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	27,933	70,436	1,888	227	8,039	30.00
31.00	INTENSIVE CARE UNIT	3,221	8,114	304	24	1,208	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	4,854	12,137	192	31	515	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	6,613	0	735	2,113	14,461	50.00
50.01	GI LAB	3,255	0	1,597	34	5,996	50.01
50.02	AMBULATORY CARE UNIT	3,080	0	198	7	431	50.02
51.00	RECOVERY ROOM	1,108	0	22	0	631	51.00
53.00	ANESTHESIOLOGY	0	0	804	1,181	2,105	53.00
54.00	RADIOLOGY-DIAGNOSTIC	7,715	0	1,613	787	17,403	54.00
60.00	LABORATORY	5,833	0	1,273	104	11,442	60.00
65.00	RESPIRATORY THERAPY	2,612	0	362	298	3,194	65.00
66.00	PHYSICAL THERAPY	4,039	0	137	1,737	3,075	66.00
69.00	ELECTROCARDIOLOGY	357	0	6	0	1,280	69.00
69.01	CATH LAB	1,368	0	38	0	3,984	69.01
70.00	ELECTROENCEPHALOGRAPHY	372	0	48	0	562	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	7,397	5	4,807	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	66,250	8,740	73.00
76.00	DIABETIC EDUCATION	6	0	0	0	21	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	846	111	604	90.00
91.00	EMERGENCY	8,649	21,693	1,552	168	6,395	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	0	0	86	4,114	1,839	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	90,542	112,380	19,115	77,191	96,732	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	162	0	1	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	NA VOLUNTEER SERVICES	60	0	0	0	0	192.03
192.04	SMART STEPS	0	0	0	0	0	192.04
192.05	RESPITE CARE	183	0	0	0	0	192.05
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
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)	90,947	112,380	19,116	77,191	96,732	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II | Date/Time Prepared: 5/24/2012 11:36 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
5.00	ADMINISTRATIVE & GENERAL					5.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
14.00	CENTRAL SERVICES & SUPPLY					14.00
15.00	PHARMACY					15.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	1,094,048	0	1,094,048		30.00
31.00	INTENSIVE CARE UNIT	185,399	0	185,399		31.00
43.00	NURSERY	0	0	0		43.00
44.00	SKILLED NURSING FACILITY	181,474	0	181,474		44.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	623,737	0	623,737		50.00
50.01	GI LAB	156,837	0	156,837		50.01
50.02	AMBULATORY CARE UNIT	124,993	0	124,993		50.02
51.00	RECOVERY ROOM	24,036	0	24,036		51.00
53.00	ANESTHESIOLOGY	118,197	0	118,197		53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,021,173	0	1,021,173		54.00
60.00	LABORATORY	279,630	0	279,630		60.00
65.00	RESPIRATORY THERAPY	115,759	0	115,759		65.00
66.00	PHYSICAL THERAPY	175,103	0	175,103		66.00
69.00	ELECTROCARDIOLOGY	32,364	0	32,364		69.00
69.01	CATH LAB	132,385	0	132,385		69.01
70.00	ELECTROENCEPHALOGRAPHY	30,460	0	30,460		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,593	0	17,593		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	113,838	0	113,838		73.00
76.00	DIABETIC EDUCATION	4,635	0	4,635		76.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	7,701	0	7,701		90.00
91.00	EMERGENCY	292,764	0	292,764		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
	SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE					113.00
116.00	HOSPICE	36,053	0	36,053		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	4,768,179	0	4,768,179		118.00
	NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,049	0	8,049		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	1,476	0	1,476		192.00
192.01	JANE ADDAMS BLDG	0	0	0		192.01
192.02	SENIOR PROGRAM	0	0	0		192.02
192.03	NA VOLUNTEER SERVICES	471	0	471		192.03
192.04	SMART STEPS	0	0	0		192.04
192.05	RESPITE CARE	900	0	900		192.05
193.00	NONPAID WORKERS	0	0	0		193.00
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)	4,779,075	0	4,779,075		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/24/2012 11:36 am

	Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	293,311					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		2,964,956				2.00
4.00	EMPLOYEE BENEFITS	1,876	318	30,579,544			4.00
5.00	ADMINISTRATIVE & GENERAL	49,468	526,119	2,196,403	-18,365,384	69,065,521	5.00
7.00	OPERATION OF PLANT	33,701	30,072	211,114	0	3,670,675	7.00
8.00	LAUNDRY & LINEN SERVICE	2,258	0	0	0	588,769	8.00
9.00	HOUSEKEEPING	4,954	9,089	0	0	1,880,625	9.00
10.00	DIETARY	11,151	24,366	0	0	923,966	10.00
11.00	CAFETERIA	9,517	0	0	0	1,307,014	11.00
13.00	NURSING ADMINISTRATION	360	97,370	590,283	0	880,563	13.00
14.00	CENTRAL SERVICES & SUPPLY	861	156	70,228	0	962,697	14.00
15.00	PHARMACY	2,341	31,393	1,120,727	0	1,962,452	15.00
16.00	MEDICAL RECORDS & LIBRARY	4,219	36,392	1,013,909	0	1,847,836	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	54,927	294,525	8,291,771	0	12,066,564	30.00
31.00	INTENSIVE CARE UNIT	4,162	110,338	1,268,083	0	1,838,615	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	14,080	12,321	1,133,237	0	1,632,428	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	20,863	348,668	1,742,194	0	7,053,918	50.00
50.01	GI LAB	6,730	66,493	954,191	0	2,033,215	50.01
50.02	AMBULATORY CARE UNIT	9,043	28,147	1,021,057	0	1,571,440	50.02
51.00	RECOVERY ROOM	1,609	520	511,141	0	682,245	51.00
53.00	ANESTHESIOLOGY	830	104,086	0	0	296,561	53.00
54.00	RADIOLOGY-DIAGNOSTIC	16,875	784,351	1,859,427	0	6,115,600	54.00
60.00	LABORATORY	8,547	141,321	1,400,015	0	4,290,579	60.00
65.00	RESPIRATORY THERAPY	7,022	37,811	716,858	0	1,307,495	65.00
66.00	PHYSICAL THERAPY	10,944	42,520	2,034,214	0	2,998,739	66.00
69.00	ELECTROCARDIOLOGY	632	22,355	165,460	0	276,434	69.00
69.01	CATH LAB	600	99,110	477,532	0	1,912,675	69.01
70.00	ELECTROENCEPHALOGRAPHY	1,171	18,141	102,379	0	171,278	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	446,443	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,221,190	73.00
76.00	DIABETIC EDUCATION	406	0	1,275	0	116,047	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	509,123	90.00
91.00	EMERGENCY	13,214	93,559	2,723,766	0	4,244,239	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	0	5,415	889,210	0	2,011,354	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	292,361	2,964,956	30,494,474	-18,365,384	68,820,779	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	765	0	24,255	0	152,048	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	185	0	0	0	1,146	192.00
192.01	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	NA VOLUNTEER SERVICES	0	0	17,655	0	33,522	192.03
192.04	SMART STEPS	0	0	0	0	0	192.04
192.05	RESPITE CARE	0	0	43,160	0	58,026	192.05
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
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)	1,817,369	2,961,706	6,108,126		18,365,384	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6.196048	0.998904	0.199745		0.265912	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			11,942		832,907	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000391		0.012060	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/24/2012 11:36 am

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		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
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT	208,266					7.00
8.00	LAUNDRY & LINEN SERVICE	2,258	459,783				8.00
9.00	HOUSEKEEPING	4,954	0	201,054			9.00
10.00	DIETARY	11,151	0	11,151	70,507		10.00
11.00	CAFETERIA	9,517	0	9,517	0	42,755	11.00
13.00	NURSING ADMINISTRATION	360	0	360	0	668	13.00
14.00	CENTRAL SERVICES & SUPPLY	861	0	861	0	245	14.00
15.00	PHARMACY	2,341	0	2,341	0	1,512	15.00
16.00	MEDICAL RECORDS & LIBRARY	4,219	0	4,219	0	2,054	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	54,927	190,721	54,927	56,289	13,131	30.00
31.00	INTENSIVE CARE UNIT	4,162	16,688	4,162	3,357	1,514	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	14,080	19,792	14,080	10,861	2,282	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	20,863	18,262	20,863	0	3,109	50.00
50.01	GI LAB	6,730	28,058	6,730	0	1,530	50.01
50.02	AMBULATORY CARE UNIT	9,043	45,103	9,043	0	1,448	50.02
51.00	RECOVERY ROOM	1,609	11,735	1,609	0	521	51.00
53.00	ANESTHESIOLOGY	830	0	830	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	16,875	45,065	16,875	0	3,627	54.00
60.00	LABORATORY	8,547	0	8,547	0	2,742	60.00
65.00	RESPIRATORY THERAPY	7,022	0	7,022	0	1,228	65.00
66.00	PHYSICAL THERAPY	10,944	4,256	10,944	0	1,899	66.00
69.00	ELECTROCARDIOLOGY	632	0	632	0	168	69.00
69.01	CATH LAB	600	0	600	0	643	69.01
70.00	ELECTROENCEPHALOGRAPHY	1,171	0	1,171	0	175	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	DIABETIC EDUCATION	406	0	406	0	3	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	13,214	80,103	13,214	0	4,066	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	207,316	459,783	200,104	70,507	42,565	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	765	0	765	0	76	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	185	0	185	0	0	192.00
192.01	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	NA VOLUNTEER SERVICES	0	0	0	0	28	192.03
192.04	SMART STEPS	0	0	0	0	0	192.04
192.05	RESPITE CARE	0	0	0	0	86	192.05
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
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)	4,646,752	795,710	2,491,238	1,556,628	1,984,829	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	22.311621	1.730621	12.390890	22.077638	46.423319	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	283,203	24,162	69,191	123,575	90,947	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.359814	0.052551	0.344141	1.752663	2.127166	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/24/2012 11:36 am

	Cost Center Description	NURSING ADMINISTRATION (DIRECT)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
		13.00	14.00	15.00	16.00		
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
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	499,657					13.00
14.00	CENTRAL SERVICES & SUPPLY	0	2,260,559				14.00
15.00	PHARMACY	0	2,051	3,572,055			15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	275,453,861		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	313,171	223,287	10,517	22,904,231		30.00
31.00	INTENSIVE CARE UNIT	36,076	35,988	1,099	3,441,277		31.00
43.00	NURSERY	0	0	0	0		43.00
44.00	SKILLED NURSING FACILITY	53,962	22,675	1,440	1,466,477		44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	86,890	97,781	41,199,874		50.00
50.01	GI LAB	0	188,884	1,559	17,082,997		50.01
50.02	AMBULATORY CARE UNIT	0	23,382	301	1,228,393		50.02
51.00	RECOVERY ROOM	0	2,627	0	1,797,828		51.00
53.00	ANESTHESIOLOGY	0	95,095	54,634	5,996,949		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	190,760	36,413	49,446,836		54.00
60.00	LABORATORY	0	150,557	4,809	32,598,419		60.00
65.00	RESPIRATORY THERAPY	0	42,840	13,787	9,099,296		65.00
66.00	PHYSICAL THERAPY	0	16,162	80,372	8,761,013		66.00
69.00	ELECTROCARDIOLOGY	0	682	0	3,645,974		69.00
69.01	CATH LAB	0	4,475	0	11,349,549		69.01
70.00	ELECTROENCEPHALOGRAPHY	0	5,733	0	1,602,183		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	874,579	218	13,693,987		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	3,065,845	24,898,872		73.00
76.00	DIABETIC EDUCATION	0	0	0	59,053		76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	100,087	5,141	1,719,728		90.00
91.00	EMERGENCY	96,448	183,536	7,767	18,220,659		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	0	10,113	190,372	5,240,266		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	499,657	2,260,403	3,572,055	275,453,861		118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	156	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	JANE ADDAMS BLDG	0	0	0	0		192.01
192.02	SENIOR PROGRAM	0	0	0	0		192.02
192.03	NA VOLUNTEER SERVICES	0	0	0	0		192.03
192.04	SMART STEPS	0	0	0	0		192.04
192.05	RESPITE CARE	0	0	0	0		192.05
193.00	NONPAID WORKERS	0	0	0	0		193.00
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)	1,158,219	1,259,943	2,636,866	2,580,961		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2.318028	0.557359	0.738193	0.009370		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	112,380	19,116	77,191	96,732		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.224914	0.008456	0.021610	0.000351		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	20,436,488		20,436,488	0	20,436,488	30.00
31.00	INTENSIVE CARE UNIT	2,781,977		2,781,977	0	2,781,977	31.00
43.00	NURSERY	0		0	0	0	43.00
44.00	SKILLED NURSING FACILITY	3,087,624		3,087,624	0	3,087,624	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	10,336,225		10,336,225	0	10,336,225	50.00
50.01	GI LAB	3,193,500		3,193,500	0	3,193,500	50.01
50.02	AMBULATORY CARE UNIT	2,473,161		2,473,161	0	2,473,161	50.02
51.00	RECOVERY ROOM	982,304		982,304	0	982,304	51.00
53.00	ANESTHESIOLOGY	553,746		553,746	0	553,746	53.00
54.00	RADIOLOGY-DIAGNOSTIC	9,170,260		9,170,260	0	9,170,260	54.00
60.00	LABORATORY	6,248,301		6,248,301	0	6,248,301	60.00
65.00	RESPIRATORY THERAPY	2,075,177	0	2,075,177	0	2,075,177	65.00
66.00	PHYSICAL THERAPY	4,421,877	0	4,421,877	0	4,421,877	66.00
69.00	ELECTROCARDIOLOGY	414,215		414,215	0	414,215	69.00
69.01	CATH LAB	2,580,789		2,580,789	0	2,580,789	69.01
70.00	ELECTROENCEPHALOGRAPHY	283,791		283,791	0	283,791	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,181,089		1,181,089	0	1,181,089	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	6,574,231		6,574,231	0	6,574,231	73.00
76.00	DIABETIC EDUCATION	161,687		161,687	0	161,687	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	720,198		720,198	0	720,198	90.00
91.00	EMERGENCY	6,661,103		6,661,103	0	6,661,103	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	2,553,849		2,553,849		2,553,849	92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	2,741,466		2,741,466		2,741,466	116.00
200.00	Subtotal (see instructions)	89,633,058	0	89,633,058	0	89,633,058	200.00
201.00	Less Observation Beds	2,553,849		2,553,849		2,553,849	201.00
202.00	Total (see instructions)	87,079,209	0	87,079,209	0	87,079,209	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	19,928,889		19,928,889			30.00
31.00	INTENSIVE CARE UNIT	3,441,277		3,441,277			31.00
43.00	NURSERY	0		0			43.00
44.00	SKILLED NURSING FACILITY	1,466,477		1,466,477			44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	17,046,904	24,152,970	41,199,874	0.250880	0.000000	50.00
50.01	GI LAB	2,741,661	14,341,336	17,082,997	0.186940	0.000000	50.01
50.02	AMBULATORY CARE UNIT	433,112	795,281	1,228,393	2.013330	0.000000	50.02
51.00	RECOVERY ROOM	725,052	1,072,776	1,797,828	0.546384	0.000000	51.00
53.00	ANESTHESIOLOGY	2,031,512	3,965,437	5,996,949	0.092338	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	7,993,940	41,452,896	49,446,836	0.185457	0.000000	54.00
60.00	LABORATORY	10,579,582	22,018,837	32,598,419	0.191675	0.000000	60.00
65.00	RESPIRATORY THERAPY	6,898,588	2,200,708	9,099,296	0.228059	0.000000	65.00
66.00	PHYSICAL THERAPY	2,623,388	6,137,625	8,761,013	0.504722	0.000000	66.00
69.00	ELECTROCARDIOLOGY	1,313,042	2,332,932	3,645,974	0.113609	0.000000	69.00
69.01	CATH LAB	4,555,787	6,793,762	11,349,549	0.227391	0.000000	69.01
70.00	ELECTROENCEPHALOGRAPHY	33,764	1,568,419	1,602,183	0.177128	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,847,224	3,846,763	13,693,987	0.086249	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	16,273,632	8,625,240	24,898,872	0.264037	0.000000	73.00
76.00	DIABETIC EDUCATION	0	59,053	59,053	2.737998	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	156	1,719,572	1,719,728	0.418786	0.000000	90.00
91.00	EMERGENCY	4,174,630	14,046,029	18,220,659	0.365580	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	89,524	2,885,818	2,975,342	0.858338	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	454	5,239,812	5,240,266			116.00
200.00	Subtotal (see instructions)	112,198,595	163,255,266	275,453,861			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	112,198,595	163,255,266	275,453,861			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	PPS Inpatient Ratio		
		11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
43.00	NURSERY			43.00
44.00	SKILLED NURSING FACILITY			44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0.250880		50.00
50.01	GI LAB	0.186940		50.01
50.02	AMBULATORY CARE UNIT	2.013330		50.02
51.00	RECOVERY ROOM	0.546384		51.00
53.00	ANESTHESIOLOGY	0.092338		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.185457		54.00
60.00	LABORATORY	0.191675		60.00
65.00	RESPIRATORY THERAPY	0.228059		65.00
66.00	PHYSICAL THERAPY	0.504722		66.00
69.00	ELECTROCARDIOLOGY	0.113609		69.00
69.01	CATH LAB	0.227391		69.01
70.00	ELECTROENCEPHALOGRAPHY	0.177128		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.086249		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.264037		73.00
76.00	DIABETIC EDUCATION	2.737998		76.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	0.418786		90.00
91.00	EMERGENCY	0.365580		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.858338		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE			113.00
116.00	HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/24/2012 11:36 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	20,436,488		20,436,488	0	0	30.00
31.00	INTENSIVE CARE UNIT	2,781,977		2,781,977	0	0	31.00
43.00	NURSERY	0		0	0	0	43.00
44.00	SKILLED NURSING FACILITY	3,087,624		3,087,624	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	10,336,225		10,336,225	0	0	50.00
50.01	GI LAB	3,193,500		3,193,500	0	0	50.01
50.02	AMBULATORY CARE UNIT	2,473,161		2,473,161	0	0	50.02
51.00	RECOVERY ROOM	982,304		982,304	0	0	51.00
53.00	ANESTHESIOLOGY	553,746		553,746	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	9,170,260		9,170,260	0	0	54.00
60.00	LABORATORY	6,248,301		6,248,301	0	0	60.00
65.00	RESPIRATORY THERAPY	2,075,177	0	2,075,177	0	0	65.00
66.00	PHYSICAL THERAPY	4,421,877	0	4,421,877	0	0	66.00
69.00	ELECTROCARDIOLOGY	414,215		414,215	0	0	69.00
69.01	CATH LAB	2,580,789		2,580,789	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	283,791		283,791	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,181,089		1,181,089	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	6,574,231		6,574,231	0	0	73.00
76.00	DIABETIC EDUCATION	161,687		161,687	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	720,198		720,198	0	0	90.00
91.00	EMERGENCY	6,661,103		6,661,103	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	2,553,849		2,553,849		0	92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	2,741,466		2,741,466		0	116.00
200.00	Subtotal (see instructions)	89,633,058	0	89,633,058	0	0	200.00
201.00	Less Observation Beds	2,553,849		2,553,849		0	201.00
202.00	Total (see instructions)	87,079,209	0	87,079,209	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/24/2012 11:36 am

Title XIX | Hospital | Cost

	Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	19,928,889		19,928,889			30.00
31.00	INTENSIVE CARE UNIT	3,441,277		3,441,277			31.00
43.00	NURSERY	0		0			43.00
44.00	SKILLED NURSING FACILITY	1,466,477		1,466,477			44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	17,046,904	24,152,970	41,199,874	0.250880	0.000000	50.00
50.01	GI LAB	2,741,661	14,341,336	17,082,997	0.186940	0.000000	50.01
50.02	AMBULATORY CARE UNIT	433,112	795,281	1,228,393	2.013330	0.000000	50.02
51.00	RECOVERY ROOM	725,052	1,072,776	1,797,828	0.546384	0.000000	51.00
53.00	ANESTHESIOLOGY	2,031,512	3,965,437	5,996,949	0.092338	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	7,993,940	41,452,896	49,446,836	0.185457	0.000000	54.00
60.00	LABORATORY	10,579,582	22,018,837	32,598,419	0.191675	0.000000	60.00
65.00	RESPIRATORY THERAPY	6,898,588	2,200,708	9,099,296	0.228059	0.000000	65.00
66.00	PHYSICAL THERAPY	2,623,388	6,137,625	8,761,013	0.504722	0.000000	66.00
69.00	ELECTROCARDIOLOGY	1,313,042	2,332,932	3,645,974	0.113609	0.000000	69.00
69.01	CATH LAB	4,555,787	6,793,762	11,349,549	0.227391	0.000000	69.01
70.00	ELECTROENCEPHALOGRAPHY	33,764	1,568,419	1,602,183	0.177128	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,847,224	3,846,763	13,693,987	0.086249	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	16,273,632	8,625,240	24,898,872	0.264037	0.000000	73.00
76.00	DIABETIC EDUCATION	0	59,053	59,053	2.737998	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	156	1,719,572	1,719,728	0.418786	0.000000	90.00
91.00	EMERGENCY	4,174,630	14,046,029	18,220,659	0.365580	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	89,524	2,885,818	2,975,342	0.858338	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	454	5,239,812	5,240,266			116.00
200.00	Subtotal (see instructions)	112,198,595	163,255,266	275,453,861			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	112,198,595	163,255,266	275,453,861			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/24/2012 11:36 am

Title XIX | Hospital | Cost

	Cost Center Description	PPS Inpatient Ratio		
		11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
43.00	NURSERY			43.00
44.00	SKILLED NURSING FACILITY			44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0.000000		50.00
50.01	GI LAB	0.000000		50.01
50.02	AMBULATORY CARE UNIT	0.000000		50.02
51.00	RECOVERY ROOM	0.000000		51.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	LABORATORY	0.000000		60.00
65.00	RESPIRATORY THERAPY	0.000000		65.00
66.00	PHYSICAL THERAPY	0.000000		66.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
69.01	CATH LAB	0.000000		69.01
70.00	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	DIABETIC EDUCATION	0.000000		76.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	0.000000		90.00
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE			113.00
116.00	HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part I Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,094,048	0	1,094,048	17,901	61.12	30.00
31.00	INTENSIVE CARE UNIT	185,399		185,399	1,576	117.64	31.00
43.00	NURSERY	0		0	1,000	0.00	43.00
44.00	SKILLED NURSING FACILITY	181,474		181,474	3,593	50.51	44.00
200.00	Total (lines 30-199)	1,460,921		1,460,921	24,070		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part I Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	8,469	517,625		30.00
31.00	INTENSIVE CARE UNIT	938	110,346		31.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	2,491	125,820		44.00
200.00	Total (lines 30-199)	11,898	753,791		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part II Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	623,737	41,199,874	0.015139	7,961,104	120,523	50.00
50.01	GI LAB	156,837	17,082,997	0.009181	1,626,521	14,933	50.01
50.02	AMBULATORY CARE UNIT	124,993	1,228,393	0.101753	349,683	35,581	50.02
51.00	RECOVERY ROOM	24,036	1,797,828	0.013369	269,142	3,598	51.00
53.00	ANESTHESIOLOGY	118,197	5,996,949	0.019710	782,128	15,416	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,021,173	49,446,836	0.020652	4,861,785	100,406	54.00
60.00	LABORATORY	279,630	32,598,419	0.008578	4,665,228	40,018	60.00
65.00	RESPIRATORY THERAPY	115,759	9,099,296	0.012722	4,190,066	53,306	65.00
66.00	PHYSICAL THERAPY	175,103	8,761,013	0.019987	1,199,957	23,984	66.00
69.00	ELECTROCARDIOLOGY	32,364	3,645,974	0.008877	859,923	7,634	69.00
69.01	CATH LAB	132,385	11,349,549	0.011664	2,468,851	28,797	69.01
70.00	ELECTROENCEPHALOGRAPHY	30,460	1,602,183	0.019012	18,860	359	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,593	13,693,987	0.001285	5,153,168	6,622	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	113,838	24,898,872	0.004572	8,629,829	39,456	73.00
76.00	DIABETIC EDUCATION	4,635	59,053	0.078489	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	7,701	1,719,728	0.004478	156	1	90.00
91.00	EMERGENCY	292,764	18,220,659	0.016068	2,323,690	37,337	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	136,718	2,975,342	0.045950	58,467	2,687	92.00
200.00	Total (lines 50-199)	3,407,923	245,376,952		45,418,558	530,658	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part III Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Hospital | PPS

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part III Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
		6.00	7.00	8.00	9.00	11.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	17,901	0.00	8,469	0	0	30.00
31.00	INTENSIVE CARE UNIT	1,576	0.00	938	0	0	31.00
43.00	NURSERY	1,000	0.00	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	3,593	0.00	2,491	0	0	44.00
200.00	Total (lines 30-199)	24,070		11,898	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part III Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost	
		12.00	13.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
50.01	GI LAB	0	0	0	0	0	50.01
50.02	AMBULATORY CARE UNIT	0	0	0	0	0	50.02
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
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
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	CATH LAB	0	0	0	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	DIABETIC EDUCATION	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	41,199,874	0.000000	0.000000	7,961,104	50.00
50.01	GI LAB	0	17,082,997	0.000000	0.000000	1,626,521	50.01
50.02	AMBULATORY CARE UNIT	0	1,228,393	0.000000	0.000000	349,683	50.02
51.00	RECOVERY ROOM	0	1,797,828	0.000000	0.000000	269,142	51.00
53.00	ANESTHESIOLOGY	0	5,996,949	0.000000	0.000000	782,128	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	49,446,836	0.000000	0.000000	4,861,785	54.00
60.00	LABORATORY	0	32,598,419	0.000000	0.000000	4,665,228	60.00
65.00	RESPIRATORY THERAPY	0	9,099,296	0.000000	0.000000	4,190,066	65.00
66.00	PHYSICAL THERAPY	0	8,761,013	0.000000	0.000000	1,199,957	66.00
69.00	ELECTROCARDIOLOGY	0	3,645,974	0.000000	0.000000	859,923	69.00
69.01	CATH LAB	0	11,349,549	0.000000	0.000000	2,468,851	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	1,602,183	0.000000	0.000000	18,860	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,693,987	0.000000	0.000000	5,153,168	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	24,898,872	0.000000	0.000000	8,629,829	73.00
76.00	DIABETIC EDUCATION	0	59,053	0.000000	0.000000	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	1,719,728	0.000000	0.000000	156	90.00
91.00	EMERGENCY	0	18,220,659	0.000000	0.000000	2,323,690	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,975,342	0.000000	0.000000	58,467	92.00
200.00	Total (lines 50-199)	0	245,376,952			45,418,558	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	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	8,146,115	0	0	0	50.00
50.01	GI LAB	0	5,127,456	0	0	0	50.01
50.02	AMBULATORY CARE UNIT	0	409,394	0	0	0	50.02
51.00	RECOVERY ROOM	0	193,265	0	0	0	51.00
53.00	ANESTHESIOLOGY	0	1,179,539	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	11,128,346	0	0	0	54.00
60.00	LABORATORY	0	604,700	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	901,635	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	474,724	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	950,832	0	0	0	69.00
69.01	CATH LAB	0	3,237,343	0	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	491,381	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,131,111	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,850,342	0	0	0	73.00
76.00	DIABETIC EDUCATION	0	342	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	1,351,588	0	0	0	90.00
91.00	EMERGENCY	0	2,994,968	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,209,841	0	0	0	92.00
200.00	Total (lines 50-199)	0	42,382,922	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0		50.00
50.01	GI LAB	0	0		50.01
50.02	AMBULATORY CARE UNIT	0	0		50.02
51.00	RECOVERY ROOM	0	0		51.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	LABORATORY	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
69.01	CATH LAB	0	0		69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	DIABETIC EDUCATION	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	0		90.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.250880	8,146,115	0	0		50.00
50.01	GI LAB	0.186940	5,127,456	0	0		50.01
50.02	AMBULATORY CARE UNIT	2.013330	409,394	0	0		50.02
51.00	RECOVERY ROOM	0.546384	193,265	0	0		51.00
53.00	ANESTHESIOLOGY	0.092338	1,179,539	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.185457	11,128,346	0	0		54.00
60.00	LABORATORY	0.191675	604,700	0	0		60.00
65.00	RESPIRATORY THERAPY	0.228059	901,635	0	0		65.00
66.00	PHYSICAL THERAPY	0.504722	474,724	0	0		66.00
69.00	ELECTROCARDIOLOGY	0.113609	950,832	0	0		69.00
69.01	CATH LAB	0.227391	3,237,343	0	0		69.01
70.00	ELECTROENCEPHALOGRAPHY	0.177128	491,381	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.086249	1,131,111	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.264037	2,850,342	0	38,119		73.00
76.00	DIABETIC EDUCATION	2.737998	342	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0.418786	1,351,588	0	0		90.00
91.00	EMERGENCY	0.365580	2,994,968	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.858338	1,209,841	0	0		92.00
200.00	Subtotal (see instructions)		42,382,922	0	38,119		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		42,382,922	0	38,119		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	Costs: PPS Services (see instructions)	Costs: Cost Services Subject To Ded. & Coins. (see instructions)	Costs: Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	2,043,697	0	0		50.00
50.01	GI LAB	958,527	0	0		50.01
50.02	AMBULATORY CARE UNIT	824,245	0	0		50.02
51.00	RECOVERY ROOM	105,597	0	0		51.00
53.00	ANESTHESIOLOGY	108,916	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,063,830	0	0		54.00
60.00	LABORATORY	115,906	0	0		60.00
65.00	RESPIRATORY THERAPY	205,626	0	0		65.00
66.00	PHYSICAL THERAPY	239,604	0	0		66.00
69.00	ELECTROCARDIOLOGY	108,023	0	0		69.00
69.01	CATH LAB	736,143	0	0		69.01
70.00	ELECTROENCEPHALOGRAPHY	87,037	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	97,557	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	752,596	0	10,065		73.00
76.00	DIABETIC EDUCATION	936	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	566,026	0	0		90.00
91.00	EMERGENCY	1,094,900	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1,038,453	0	0		92.00
200.00	Subtotal (see instructions)	11,147,619	0	10,065		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	11,147,619	0	10,065		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140160 | Component CCN: 145531 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/24/2012 11:36 am

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
50.01	GI LAB	0	0	0	0	0	50.01
50.02	AMBULATORY CARE UNIT	0	0	0	0	0	50.02
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
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
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	CATH LAB	0	0	0	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	DIABETIC EDUCATION	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 140160 Component CCN: 145531 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV Date/Time Prepared: 5/24/2012 11:36 am

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	41,199,874	0.000000	0.000000	411	50.00
50.01	GI LAB	0	17,082,997	0.000000	0.000000	1,283	50.01
50.02	AMBULATORY CARE UNIT	0	1,228,393	0.000000	0.000000	1,521	50.02
51.00	RECOVERY ROOM	0	1,797,828	0.000000	0.000000	0	51.00
53.00	ANESTHESIOLOGY	0	5,996,949	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	49,446,836	0.000000	0.000000	30,901	54.00
60.00	LABORATORY	0	32,598,419	0.000000	0.000000	131,007	60.00
65.00	RESPIRATORY THERAPY	0	9,099,296	0.000000	0.000000	440,923	65.00
66.00	PHYSICAL THERAPY	0	8,761,013	0.000000	0.000000	614,800	66.00
69.00	ELECTROCARDIOLOGY	0	3,645,974	0.000000	0.000000	1,756	69.00
69.01	CATH LAB	0	11,349,549	0.000000	0.000000	2,755	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	1,602,183	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,693,987	0.000000	0.000000	399,451	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	24,898,872	0.000000	0.000000	1,078,795	73.00
76.00	DIABETIC EDUCATION	0	59,053	0.000000	0.000000	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	1,719,728	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	18,220,659	0.000000	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,975,342	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	245,376,952			2,703,603	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140160 | Component CCN: 145531 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	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
50.01	GI LAB	0	0	0	0	0	50.01
50.02	AMBULATORY CARE UNIT	0	0	0	0	0	50.02
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
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
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	CATH LAB	0	0	0	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	DIABETIC EDUCATION	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 140160 | Component CCN: 145531 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0		50.00
50.01	GI LAB	0	0		50.01
50.02	AMBULATORY CARE UNIT	0	0		50.02
51.00	RECOVERY ROOM	0	0		51.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	LABORATORY	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
69.01	CATH LAB	0	0		69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	DIABETIC EDUCATION	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	0		90.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	17,901	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,901	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)	17,901	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)	8,469	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	20,436,488	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)	20,436,488	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	25,155,844	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	25,155,844	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.812395	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,405.28	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)	20,436,488	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,141.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	9,668,549	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)	9,668,549	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,781,977	1,576	1,765.21	938	1,655,767	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	10,866,957	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	22,191,273	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)	627,971	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	530,658	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,158,629	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	21,032,644	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,237	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,141.64	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,553,849	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,094,048	20,436,488	0.053534	2,553,849	136,718	90.00
91.00	Nursing School cost	0	20,436,488	0.000000	2,553,849	0	91.00
92.00	Allied health cost	0	20,436,488	0.000000	2,553,849	0	92.00
93.00	All other Medical Education	0	20,436,488	0.000000	2,553,849	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140160 Component CCN: 145531	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/24/2012 11:36 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)	3,593	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,593	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)	3,593	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,491	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,087,624	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)	3,087,624	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,466,477	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,466,477	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	2.105470	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)	408.15	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)	3,087,624	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: 140160 | Component CCN: 145531 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/24/2012 11:36 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)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	3,087,624	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	859.34	71.00
72.00	Program routine service cost (line 9 x line 71)	2,140,616	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)	2,140,616	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)	2,140,616	83.00
84.00	Program inpatient ancillary services (see instructions)	765,225	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,905,841	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: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1

Component CCN: 145531 | Date/Time Prepared: 5/24/2012 11:36 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: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-3 | Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Hospital | PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		9,656,064		30.00
31.00	INTENSIVE CARE UNIT		2,046,584		31.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.250880	7,961,104	1,997,282	50.00
50.01	GI LAB	0.186940	1,626,521	304,062	50.01
50.02	AMBULATORY CARE UNIT	2.013330	349,683	704,027	50.02
51.00	RECOVERY ROOM	0.546384	269,142	147,055	51.00
53.00	ANESTHESIOLOGY	0.092338	782,128	72,220	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.185457	4,861,785	901,652	54.00
60.00	LABORATORY	0.191675	4,665,228	894,208	60.00
65.00	RESPIRATORY THERAPY	0.228059	4,190,066	955,582	65.00
66.00	PHYSICAL THERAPY	0.504722	1,199,957	605,645	66.00
69.00	ELECTROCARDIOLOGY	0.113609	859,923	97,695	69.00
69.01	CATH LAB	0.227391	2,468,851	561,394	69.01
70.00	ELECTROENCEPHALOGRAPHY	0.177128	18,860	3,341	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.086249	5,153,168	444,456	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.264037	8,629,829	2,278,594	73.00
76.00	DIABETIC EDUCATION	2.737998	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0.418786	156	65	90.00
91.00	EMERGENCY	0.365580	2,323,690	849,495	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.858338	58,467	50,184	92.00
200.00	Total (sum of lines 50-94 and 96-98)		45,418,558	10,866,957	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)		45,418,558		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140160 | Component CCN: 145531 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-3 | Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.250880	411	103	50.00
50.01	GI LAB	0.186940	1,283	240	50.01
50.02	AMBULATORY CARE UNIT	2.013330	1,521	3,062	50.02
51.00	RECOVERY ROOM	0.546384	0	0	51.00
53.00	ANESTHESIOLOGY	0.092338	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.185457	30,901	5,731	54.00
60.00	LABORATORY	0.191675	131,007	25,111	60.00
65.00	RESPIRATORY THERAPY	0.228059	440,923	100,556	65.00
66.00	PHYSICAL THERAPY	0.504722	614,800	310,303	66.00
69.00	ELECTROCARDIOLOGY	0.113609	1,756	199	69.00
69.01	CATH LAB	0.227391	2,755	626	69.01
70.00	ELECTROENCEPHALOGRAPHY	0.177128	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.086249	399,451	34,452	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.264037	1,078,795	284,842	73.00
76.00	DIABETIC EDUCATION	2.737998	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0.418786	0	0	90.00
91.00	EMERGENCY	0.365580	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.858338	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,703,603	765,225	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		2,703,603		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140160	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part A Date/Time Prepared: 5/24/2012 11:36 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS		
1.00	DRG Amounts Other than Outlier Payments	15,171,494	1.00
2.00	Outlier payments for discharges. (see instructions)	308,557	2.00
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	93.87	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjusment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment. (see instructions)	0.000000	27.00
28.00	IME Adjustment (see instructions)	0	28.00
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.25	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)	18.48	31.00
32.00	Sum of lines 30 and 31	21.73	32.00
33.00	Allowable disproportionate share percentage (see instructions)	7.14	33.00
34.00	Disproportionate share adjustment (see instructions)	1,083,245	34.00
	Additional payment for high percentage of ESRD beneficiary discharges		
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)	0	46.00
47.00	Subtotal (see instructions)	16,563,296	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	16,927,651	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	16,836,562	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	1,238,145	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)	0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)	0	56.00
57.00	Routine service other pass through costs	0	57.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140160	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part A Date/Time Prepared: 5/24/2012 11:36 am
	Title XVIII	Hospital	PPS

		1.00	
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	18,074,707	59.00
60.00	Primary payer payments	9,639	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	18,065,068	61.00
62.00	Deductibles billed to program beneficiaries	1,837,824	62.00
63.00	Coinsurance billed to program beneficiaries	20,942	63.00
64.00	Allowable bad debts (see instructions)	415,049	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	290,534	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	371,902	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	16,496,836	67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)	0	68.00
69.00	Outlier payments reconciliation	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.95	Recovery of Accelerated Depreciation	0	70.95
70.96	Low Volume Payment-1	0	70.96
70.97	Low Volume Payment-2	0	70.97
70.98	Low Volume Payment-3	0	70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	16,496,836	71.00
72.00	Interim payments	16,403,565	72.00
73.00	Tentative settlement (for contractor use only)	0	73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)	93,271	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	75.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Operating outlier amount from Worksheet E, Part A line 2	0	90.00
91.00	Capital outlier from Worksheet L, Part I, line 2	0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)	0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)	0	93.00
94.00	The rate used to calculate the Time Value of Money	0.00	94.00
95.00	Time Value of Money for operating expenses(see instructions)	0	95.00
96.00	Time Value of Money for capital related expenses (see instructions)	0	96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140160	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/24/2012 11:36 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	10,065	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	11,147,619	2.00
3.00	PPS payments	9,318,857	3.00
4.00	Outlier payment (see instructions)	21,602	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.822	5.00
6.00	Line 2 times line 5	9,163,343	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	10,065	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	38,119	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)	38,119	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)	38,119	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	28,054	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)	10,065	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)	9,340,459	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,247,834	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)	7,102,690	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)	7,102,690	30.00
31.00	Primary payer payments	161	31.00
32.00	Subtotal (line 30 minus line 31)	7,102,529	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)	393,168	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	275,218	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	381,862	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	7,377,747	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)	7,377,747	40.00
41.00	Interim payments	7,414,964	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)	-37,217	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: 140160	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/24/2012 11:36 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140160 Component CCN: 145531	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/24/2012 11:36 am
	Title XVIII	Skilled Nursing Facility	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140160 Component CCN: 145531	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/24/2012 11:36 am
	Title XVIII	Skilled Nursing Facility	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		16,403,565		7,414,964	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		16,403,565		7,414,964	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		93,271		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		37,217	6.02
7.00	Total Medicare program liability (see instructions)		16,496,836		7,377,747	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140160 Component CCN: 145531 | Period: From 01/01/2011 To 12/31/2011 | Worksheet E-1 Part I Date/Time Prepared: 5/24/2012 11:36 am

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		875,639		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		875,639		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		6,953		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		882,592		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	Provider CCN: 140160 Component CCN: 145531	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VI Date/Time Prepared: 5/24/2012 11:36 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	928,702	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)	928,702	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	53,063	7.00
8.00	Allowable bad debts (see instructions)	9,933	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Allowable reimbursable bad debts (see instructions)	6,953	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)	882,592	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	882,592	15.00
16.00	Interim payments	875,639	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)	6,953	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: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G | Date/Time Prepared: 5/24/2012 11:36 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURENT ASSETS					
1.00	Cash on hand in banks	6,657,379	0	0	0	1.00
2.00	Temporary investments	9,605,412	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	21,916,729	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	5,337,846	0	0	0	9.00
10.00	Due from other funds	1,237,392	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	44,754,758	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	24,974,751	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	24,974,751	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,519,853	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,519,853	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	71,249,362	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,000,965	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,615,207	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	6,931,804	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	18,547,976	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	16,037,559	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	16,037,559	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	34,585,535	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	36,663,827				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	36,663,827	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	71,249,362	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-1 | Date/Time Prepared: 5/24/2012 11:36 am

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		39,844,527		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3,180,700				2.00
3.00	Total (sum of line 1 and line 2)		36,663,827		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0			4.00
5.00		0		0			5.00
6.00		0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		36,663,827		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)		36,663,827		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-1 | Date/Time Prepared: 5/24/2012 11:36 am

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-2 Parts | Date/Time Prepared: 5/24/2012 11:36 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	25,155,844		25,155,844	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,466,477		1,466,477	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	26,622,321		26,622,321	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,441,277		3,441,277	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)	3,441,277		3,441,277	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	30,063,598		30,063,598	17.00
18.00	Ancillary services	86,120,778	150,472,745	236,593,523	18.00
19.00	Outpatient services	6,834,294	27,674,284	34,508,578	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				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	454	5,239,812	5,240,266	26.00
27.00	DIETARY	0	13,776	13,776	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	123,019,124	183,400,617	306,419,741	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		99,069,081		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		99,069,081		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-3 | Date/Time Prepared: 5/24/2012 11:36 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	306,419,741	1.00
2.00	Less contractual allowances and discounts on patients' accounts	180,896,213	2.00
3.00	Net patient revenues (line 1 minus line 2)	125,523,528	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	99,069,081	4.00
5.00	Net income from service to patients (line 3 minus line 4)	26,454,447	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MEDICAID ASSESSMENT	5,560,598	24.00
24.01	OTHER GOV REV	785,501	24.01
24.02	OTHER OP REV	740,009	24.02
24.03	NET ASSETS	236,201	24.03
24.04	OTHER NON-OP	121,029	24.04
24.05		0	24.05
24.06		0	24.06
24.07		0	24.07
25.00	Total other income (sum of lines 6-24)	7,443,338	25.00
26.00	Total (line 5 plus line 25)	33,897,785	26.00
27.00	TRANSFER TO OTHER AFFILIATES	19,652,201	27.00
27.01	CHARITY CARE	7,617,286	27.01
27.02	BAD DEBT	9,808,984	27.02
27.03	ROUNDING	14	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	37,078,485	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-3,180,700	29.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140160 Hospice CCN: 141560 | Period: From 01/01/2011 To 12/31/2011 | Worksheet K | Date/Time Prepared: 5/24/2012 11:36 am

Hospice I

		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	179	0	113,902	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	10,121	915	530	0	10,000	9.00
10.00	Nursing Care	878,463	79,389	27,429	484,247	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	627	57	82	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	6,127	0	0	15.00
16.00	Spiritual Counseling	0	0	1,799	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	25,501	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	190,372	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	8,590	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	889,211	80,361	61,647	484,247	322,864	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140160 Hospice CCN: 141560 | Period: From 01/01/2011 To 12/31/2011 | Worksheet K | Date/Time Prepared: 5/24/2012 11:36 am

Hospice I

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	114,081	0	114,081	0	114,081	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	21,566	0	21,566	-10,000	11,566	9.00
10.00	Nursing Care	1,469,528	0	1,469,528	0	1,469,528	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	766	0	766	0	766	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	6,127	0	6,127	0	6,127	15.00
16.00	Spiritual Counseling	1,799	0	1,799	0	1,799	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	25,501	0	25,501	0	25,501	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	190,372	0	190,372	0	190,372	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	8,590	0	8,590	0	8,590	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,838,330	0	1,838,330	-10,000	1,828,330	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140160 Hospice CCN: 141560

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

Worksheet K-1

Date/Time Prepared: 5/24/2012 11:36 am

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	103,446	0	489,601	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	103,446	0	489,601	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140160 Hospice CCN: 141560

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

Worksheet K-1

Date/Time Prepared: 5/24/2012 11:36 am

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	10,121	10,121		9.00
10.00	Nursing Care		119,066	166,350	878,463		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	627	0	0	627		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	627	119,066	176,471	889,211		39.00

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

Provider CCN: 140160 Hospice CCN: 141560

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

Worksheet K-2

Date/Time Prepared: 5/24/2012 11:36 am

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	915	9.00
10.00	Nursing Care	0	0	9,349	0	44,247	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	9,349	0	45,162	39.00

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

Provider CCN: 140160 Hospice CCN: 141560

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

Worksheet K-2

Date/Time Prepared: 5/24/2012 11:36 am

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	915		9.00
10.00	Nursing Care		10,760	15,033	79,389		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	57	0	0	57		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	57	10,760	15,033	80,361		39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES

Provider CCN: 140160 Hospice CCN: 141560

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

Worksheet K-3

Date/Time Prepared: 5/24/2012 11:36 am

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	484,247	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	484,247	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 140160 | Hospice CCN: 141560 | Period: From 01/01/2011 To 12/31/2011 | Worksheet K-3 | Date/Time Prepared: 5/24/2012 11:36 am

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	0	484,247		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	484,247		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140160 Hospice CCN: 141560

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

Worksheet K-4 Part I Date/Time Prepared: 5/24/2012 11:36 am

Hospice I

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	114,081	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	11,566	0	0	0	0	9.00
10.00	Nursing Care	1,469,528	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	766	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	6,127	0	0	0	0	15.00
16.00	Spiritual Counseling	1,799	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	25,501	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	190,372	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	8,590	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,828,330	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST | Provider CCN: 140160 Hospice CCN: 141560 | Period: From 01/01/2011 To 12/31/2011 | Worksheet K-4 Part I Date/Time Prepared: 5/24/2012 11:36 am

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.		0				1.00
2.00	Capital Related Costs-Movable Equip.		0				2.00
3.00	Plant Operation and Maintenance		0				3.00
4.00	Transportation - Staff		0				4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	114,081				6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0		7.00
8.00	Inpatient - Respite Care	0	0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services	0	11,566	770	12,336		9.00
10.00	Nursing Care	0	1,469,528	97,794	1,567,322		10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0		11.00
12.00	Physical Therapy	0	766	51	817		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services	0	6,127	408	6,535		15.00
16.00	Spiritual Counseling	0	1,799	120	1,919		16.00
17.00	Dietary Counseling	0	0	0	0		17.00
18.00	Counseling - Other	0	0	0	0		18.00
19.00	Home Health Aide and Homemaker	0	25,501	1,697	27,198		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		20.00
21.00	Other	0	0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	190,372	12,669	203,041		22.00
23.00	Analgesics	0	0	0	0		23.00
24.00	Sedatives / Hypnotics	0	0	0	0		24.00
25.00	Other - Specify	0	0	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0		26.00
27.00	Patient Transportation	0	0	0	0		27.00
28.00	Imaging Services	0	0	0	0		28.00
29.00	Labs and Diagnostics	0	0	0	0		29.00
30.00	Medical Supplies	0	8,590	572	9,162		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0		31.00
32.00	Radiation Therapy	0	0	0	0		32.00
33.00	Chemotherapy	0	0	0	0		33.00
34.00	Other	0	0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0		35.00
36.00	Volunteer Program Costs	0	0	0	0		36.00
37.00	Fundraising	0	0	0	0		37.00
38.00	Other Program Costs	0	0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	1,714,249	114,081	1,828,330		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140160 Hospice CCN: 141560 | Period: From 01/01/2011 To 12/31/2011 | Worksheet K-4 Part II Date/Time Prepared: 5/24/2012 11:36 am

Hospice I

		CAPITAL RELATED COST					
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT ($ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	100					1.00
2.00	Capital Related Costs-Movable Equip.	0	100				2.00
3.00	Plant Operation and Maintenance	0	0	100			3.00
4.00	Transportation - Staff	0	0	0	100		4.00
5.00	Volunteer Service Coordination	0	0	0	0	100	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	100	100	100	100	100	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0	0	0	0	39.00
40.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	40.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140160 Hospice CCN: 141560 | Period: From 01/01/2011 To 12/31/2011 | Worksheet K-4 Part II Date/Time Prepared: 5/24/2012 11:36 am

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)		
		6A	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0			1.00
2.00	Capital Related Costs-Movable Equip.	0			2.00
3.00	Plant Operation and Maintenance	0			3.00
4.00	Transportation - Staff	0			4.00
5.00	Volunteer Service Coordination				5.00
6.00	Administrative and General	-114,081	1,714,249		6.00
	INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0		7.00
8.00	Inpatient - Respite Care	0	0		8.00
	VISITING SERVICES				
9.00	Physician Services	0	11,566		9.00
10.00	Nursing Care	0	1,469,528		10.00
11.00	Nursing Care-Continuous Home Care	0	0		11.00
12.00	Physical Therapy	0	766		12.00
13.00	Occupational Therapy	0	0		13.00
14.00	Speech/ Language Pathology	0	0		14.00
15.00	Medical Social Services	0	6,127		15.00
16.00	Spiritual Counseling	0	1,799		16.00
17.00	Dietary Counseling	0	0		17.00
18.00	Counseling - Other	0	0		18.00
19.00	Home Health Aide and Homemaker	0	25,501		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		20.00
21.00	Other	0	0		21.00
	OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	190,372		22.00
23.00	Analgesics	0	0		23.00
24.00	Sedatives / Hypnotics	0	0		24.00
25.00	Other - Specify	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0		26.00
27.00	Patient Transportation	0	0		27.00
28.00	Imaging Services	0	0		28.00
29.00	Labs and Diagnostics	0	0		29.00
30.00	Medical Supplies	0	8,590		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		31.00
32.00	Radiation Therapy	0	0		32.00
33.00	Chemotherapy	0	0		33.00
34.00	Other	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0		35.00
36.00	Volunteer Program Costs	0	0		36.00
37.00	Fundraising	0	0		37.00
38.00	Other Program Costs	0	0		38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		114,081		39.00
40.00	Unit Cost Multiplier		0.066549		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140160 Hospice CCN: 141560

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

Worksheet K-5 Part I Date/Time Prepared: 5/24/2012 11:36 am

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		0	1.00	2.00	4.00	4A	
1.00	Administrative and General		0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	12,336	0	0	0	12,336	4.00
5.00	Nursing Care	1,567,322	0	5,409	177,615	1,750,346	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	817	0	0	0	817	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	6,535	0	0	0	6,535	10.00
11.00	Spiritual Counseling	1,919	0	0	0	1,919	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	27,198	0	0	0	27,198	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	203,041	0	0	0	203,041	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	9,162	0	0	0	9,162	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	1,828,330	0	5,409	177,615	2,011,354	34.00
35.00	Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140160
Hospice CCN: 141560

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

Worksheet K-5
Part I
Date/Time Prepared:
5/24/2012 11:36 am

Hospice I

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	3,280	0	0	0	0	4.00
5.00	Nursing Care	465,439	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	217	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	1,738	0	0	0	0	10.00
11.00	Spiritual Counseling	510	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	7,232	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	53,991	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	2,436	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	534,843	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140160 Hospice CCN: 141560

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

Worksheet K-5 Part I Date/Time Prepared: 5/24/2012 11:36 am

Hospice I

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	5,637	140,531	49,101	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	5,637	140,531	49,101	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140160
Hospice CCN: 141560

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

Worksheet K-5
Part I
Date/Time Prepared:
5/24/2012 11:36 am

Hospice I

	Cost Center Description	Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0					1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	15,616	0	15,616	0	15,616	4.00
5.00	Nursing Care	2,411,054	0	2,411,054	0	2,411,054	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	1,034	0	1,034	0	1,034	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	8,273	0	8,273	0	8,273	10.00
11.00	Spiritual Counseling	2,429	0	2,429	0	2,429	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	34,430	0	34,430	0	34,430	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	257,032	0	257,032	0	257,032	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	11,598	0	11,598	0	11,598	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	2,741,466	0	2,741,466		2,741,466	34.00
35.00	Unit Cost Multiplier (see instructions)				0.000000		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140160
Hospice CCN: 141560

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

Worksheet K-5
Part II
Date/Time Prepared:
5/24/2012 11:36 am

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	12,336	4.00
5.00	Nursing Care	0	5,415	889,210	0	1,750,346	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	817	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	6,535	10.00
11.00	Spiritual Counseling	0	0	0	0	1,919	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	27,198	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	203,041	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	9,162	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	5,415	889,210		2,011,354	34.00
35.00	Total cost to be allocated	0	5,409	177,615		534,843	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.998892	0.199745		0.265912	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140160
Hospice CCN: 141560

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

Worksheet K-5
Part II
Date/Time Prepared:
5/24/2012 11:36 am

Hospice I

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140160
Hospice CCN: 141560

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

Worksheet K-5
Part II
Date/Time Prepared:
5/24/2012 11:36 am

Hospice I

	Cost Center Description	NURSING ADMINISTRATION (DIRECT)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
		13.00	14.00	15.00	16.00		
1.00	Administrative and General	0	0	0	0		1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	0	0	0		4.00
5.00	Nursing Care	0	10,113	190,372	5,240,266		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00	Physical Therapy	0	0	0	0		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0	0		11.00
12.00	Dietary Counseling	0	0	0	0		12.00
13.00	Counseling - Other	0	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00	Other	0	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00	Analgesics	0	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0	0		19.00
20.00	Other - Specify	0	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00	Patient Transportation	0	0	0	0		22.00
23.00	Imaging Services	0	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0	0		24.00
25.00	Medical Supplies	0	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00	Radiation Therapy	0	0	0	0		27.00
28.00	Chemotherapy	0	0	0	0		28.00
29.00	Other	0	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0	0		31.00
32.00	Fundraising	0	0	0	0		32.00
33.00	Other Program Costs	0	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	10,113	190,372	5,240,266		34.00
35.00	Total cost to be allocated	0	5,637	140,531	49,101		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.557401	0.738192	0.009370		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 140160 Hospice CCN: 141560

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

Worksheet K-5 Part III Date/Time Prepared: 5/24/2012 11:36 am

Hospice I

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.504722	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00				2.00
3.00	SPEECH PATHOLOGY	68.00				3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.264037	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.191675	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.086249	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	DIABETIC EDUCATION	76.00	2.737998	0	0	10.00
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 140160 | Period: From 01/01/2011 To 12/31/2011 | Worksheet K-6

Hospice CCN: 141560 | Date/Time Prepared: 5/24/2012 11:36 am

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				2,741,466	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				14,597	2.00
3.00	Average cost per diem (line 1 divided by line 2)				187.81	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	13,401				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	2,516,842				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		484			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		90,900			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			712		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			133,721		13.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140160	Period: From 01/01/2011 To 12/31/2011	Worksheet L Parts I-III Date/Time Prepared: 5/24/2012 11:36 am
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier		1,230,528	1.00
2.00	Capital DRG outlier payments		7,617	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		47.23	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		1,238,145	12.00
			1.00	
	PART II - PAYMENT UNDER REASONABLE COST			
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
			1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00