

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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140015	Period: From 10/01/2011 To 09/30/2012	Worksheet 5 Parts I-III Date/Time Prepared: 2/28/2013 3:19 pm
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PART I - COST REPORT STATUS

Provider use only

1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended

6. Date Received:
 7. Contractor No.
 8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 2/28/2013 Time: 3:19 pm

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 certification 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 BLESSING HOSPITAL (140015) for the cost reporting period beginning 10/01/2011 and ending 09/30/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and 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, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information
 ECR: Date: 2/28/2013 Time: 3:19 pm
 qJabgcSUTTHO8KzfVAomVXvi9ygtY0
 4OrNx0PLZ0FPQca63bt5PLNx8ec5Jj
 yvjw1vwQL:0T9MF9
 PI: Date: 2/28/2013 Time: 3:19 pm
 QM5: iNs72CYcGT55hqh0rh.hhsf6y1
 RABJX0viUo6XovkPcFmacv6HHUNOUK
 VogmCHTsm00OkFJA

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

 Title

 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	6,332	334,661	2,010,093	0	1.00
2.00 Subprovider - IPF	0	5,620	12		0	2.00
3.00 Subprovider - IRF	0	-51,044	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	0		0	6.00
7.00 SKILLED NURSING FACILITY	0	1,546	0		0	7.00
8.00 NURSING FACILITY	0	0	0		0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	4,663		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0		0	11.00
12.00 CMHC I	0	0	0		0	12.00
200.00 Total	0	-37,546	339,336	2,010,093	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140015	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/28/2013 2:41 pm
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1.00	2.00		3.00		4.00			
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Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1005 BROADWAY			PO Box:		Zip Code: 62301		County: ADAMS		1.00
2.00	City: QUINCY			State: IL						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	BLESSING HOSPITAL	140015	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	BLESSING PSYCHIATRIC UNIT AT 14TH ST	145015	99914	4	10/01/1993	N	P	O	4.00
5.00	Subprovider - IRF	BLESSING REHAB UNIT	14T015	99914	5	10/01/1985	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	BLESSING SKILLED CARE UNIT	145643	99914		06/20/1989	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	BLESSING HOME CARE	147031	99914		12/01/1984	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HOSPICE OF ADAMS COUNT	141501	99914		06/01/1984				14.00
15.00	Hospital-Based Health Clinic - RHC	GOLDEN CLINIC	143422	99914		09/08/1996	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:			
						1.00	2.00			

20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2011	09/30/2012	20.00
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21.00	Type of Control (see instructions)	2	21.00
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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	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

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

24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	3,901	0	564	0	0	0	24.00
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25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	276	0	33	0	0	0	25.00
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						Urban/Rural S	Date of Geogr			
						1.00	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
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27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2	27.00
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35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1	35.00
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140015	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/28/2013 2:41 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	10/01/2011	09/30/2012	36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00		
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00		
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.	N		39.00		
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? 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.	Y			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.	N			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)	Y			60.00	
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-2
Part I
Date/Time Prepared:
2/28/2013 2:41 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, 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. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-2
Part I
Date/Time Prepared:
2/28/2013 2:41 pm

		1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N	N	0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N	N	0	76.00
		1.00			
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "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.				86.00
		V	XIX		
		1.00	2.00		
Title V and XIX 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		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		97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
		1.00			2.00
		3.00			4.00
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. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140015	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/28/2013 2:41 pm		
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.00	List amounts of malpractice premiums and paid losses:	734,094	1,048,525	0118.01		
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		Y	118.02		
119.00	DO NOT USE THIS LINE			119.00		
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) 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 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		Y	N	120.00	
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00	
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00	
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	14H132	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: BLESSING CORPORATE SERVICES	Contractor's Name: NATIONAL GOVERNMENT SERVICES	Contractor's Number: 131		141.00	
142.00	Street: BROADWAY AT 11TH STREET	PO Box:			142.00	
143.00	City: QUINCY	State: IL	Zip Code:	62301	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, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		Y		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	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
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	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140015	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/28/2013 2:41 pm			
1.00							
165.00	Multicampus Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		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.					Y	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)						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)					0.75	169.00

		Y/N	Date	
		1.00	2.00	
<p>General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.</p> <p>COMPLETED BY ALL HOSPITALS</p> <p>Provider Organization and Operation</p>				
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?	Y	Y	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		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.	Y		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N	
			1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		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	01/28/2013	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

		Part A		
Description		Y/N	Date	
	0	1.00	2.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	Y		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.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	Y		40.00
				1.00
				2.00
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONNIE	ZIEGLER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLESSING CORPORATE SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-223-8400, X4159	CZIEGLER@BLESSINGHOSPITAL.COM	43.00

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	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	01/28/2013	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
				3.00
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR OF REVENUE INTEGRITY		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-3
Part 1
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description	worksheet A	No. of Beds	Bed Days	CAH Hours	
	Line Number		Available		
	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	164	60,024	0.00	1.00
2.00 HMO					2.00
3.00 HMO IPF Subprovider					3.00
4.00 HMO IRF Subprovider					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)		164	60,024	0.00	7.00
8.00 INTENSIVE CARE UNIT	31.00	25	9,150	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)		189	69,174	0.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF	40.00	60	21,960		16.00
17.00 SUBPROVIDER - IRF	41.00	18	6,588		17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY	44.00	20	7,320		19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY	101.00				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE	116.00	0	0		24.00
25.00 CMHC - CMHC					25.00
26.00 RURAL HEALTH CLINIC	88.00				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00 Total (sum of lines 14-26)		287			27.00
28.00 Observation Bed Days					28.00
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

Cost Center Description	I/P Days / O/P Visits / Trips				Total All Patients	
	Title V	Title XVIII	Title XIX			
	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	20,812	4,120	32,977	1.00	
2.00 HMO		650	0		2.00	
3.00 HMO IPF Subprovider		0	0		3.00	
4.00 HMO IRF Subprovider		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	20,812	4,120	32,977	7.00	
8.00 INTENSIVE CARE UNIT	0	3,100	345	5,242	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		1,438	2,483	13.00	
14.00 Total (see instructions)	0	23,912	5,903	40,702	14.00	
15.00 CAH visits	0	0	0	0	15.00	
16.00 SUBPROVIDER - IPF	0	1,925	4,557	11,440	16.00	
17.00 SUBPROVIDER - IRF	0	3,480	309	4,949	17.00	
18.00 SUBPROVIDER					18.00	
19.00 SKILLED NURSING FACILITY	0	4,569	14	5,710	19.00	
20.00 NURSING FACILITY					20.00	
21.00 OTHER LONG TERM CARE					21.00	
22.00 HOME HEALTH AGENCY	0	27,831	0	40,107	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	0	2,665	0	7,735	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	7,936	28.00	
29.00 Ambulance Trips		0			29.00	
30.00 Employee discount days (see instruction)				674	30.00	
31.00 Employee discount days - IRF				84	31.00	
32.00 Labor & delivery days (see instructions)			0	0	32.00	
33.00 LTCH non-covered days		0			33.00	

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	5,419	1.00
2.00 HMO					147	2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						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)	16.71	1,702.96	0.00	0	5,419	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.29	28.21	0.00	0	292	16.00
17.00 SUBPROVIDER - IRF	0.46	71.46	0.00	0	274	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00	30.19	0.00			19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	41.86	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00	30.67	0.00			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00	7.41	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	17.46	1,912.76	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, observation Bed and Hospice days)	1,465	10,054		1.00
2.00 HMO				2.00
3.00 HMO IPF Subprovider				3.00
4.00 HMO IRF Subprovider				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)	1,465	10,054		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF	746	1,920		16.00
17.00 SUBPROVIDER - IRF	27	387		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: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-3
Part II
Date/Time Prepared:
2/28/2013 2:41 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from worksheet A-6)	Adjusted Salaries (col. 2 + col. 3)	Paid Hours Related to salaries in col. 4	Average Hourly wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	102,598,374	0	102,598,374	4,116,205.90	24.93
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		703,499	0	703,499	4,272.00	164.68
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		6,527,771	0	6,527,771	25,388.00	257.12
6.00	Non-physician-Part B		566,138	0	566,138	20,803.58	27.21
7.00	Interns & residents (in an approved program)	21.00	1,033,081	0	1,033,081	39,548.00	26.12
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	1,399,044	-9,364	1,389,680	64,795.55	21.45
10.00	Excluded area salaries (see instructions)		15,623,804	801,422	16,425,226	560,227.60	29.32
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		2,731	0	2,731	40.00	68.28
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office salaries & wage-related costs		441,240	0	441,240	1,588.95	277.69
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		29,289,836	0	29,289,836		17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0		18.00
19.00	Excluded areas		5,271,991	0	5,271,991		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 - Administrative		62,004	0	62,004		22.00
22.01	Physician Part A - Teaching		0	0	0		22.01
23.00	Physician Part B		191,373	0	191,373		23.00
24.00	Wage-related costs (RHC/FQHC)		134,162	0	134,162		24.00
25.00	Interns & residents (in an approved program)		356,510	0	356,510		25.00
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits	4.00	2,361,505	0	2,361,505	157,701.77	14.97
27.00	Administrative & General	5.00	12,963,165	0	12,963,165	517,502.52	25.05
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00
29.00	Maintenance & Repairs	6.00	2,351,700	0	2,351,700	116,068.74	20.26
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00
31.00	Laundry & Linen Service	8.00	64,383	0	64,383	5,550.32	11.60
32.00	Housekeeping	9.00	2,061,643	0	2,061,643	166,270.38	12.40
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	2,141,400	-1,470,285	671,115	54,489.82	12.32
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	1,470,285	1,470,285	119,719.08	12.28
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	5,270,173	-15,301	5,254,872	212,944.92	24.68
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00
41.00	Medical Records & Medical Records Library	16.00	1,722,065	0	1,722,065	105,149.26	16.38

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-3
Part II
Date/Time Prepared:
2/28/2013 2:41 pm

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 + col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 + col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
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: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-3
Part III
Date/Time Prepared:
2/28/2013 2:41 pm

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from worksheet A-6)	Adjusted Salaries (col. 2 + col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 + col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	94,471,384	0	94,471,384	4,030,466.32	23.44	1.00
2.00	Excluded area salaries (see instructions)	17,022,848	792,058	17,814,906	625,023.15	28.50	2.00
3.00	Subtotal salaries (line 1 minus line 2)	77,448,536	-792,058	76,656,478	3,405,443.17	22.51	3.00
4.00	Subtotal other wages & related costs (see inst.)	443,971	0	443,971	1,628.95	272.55	4.00
5.00	Subtotal wage-related costs (see inst.)	29,351,840	0	29,351,840	0.00	38.29	5.00
6.00	Total (sum of lines 3 thru 5)	107,244,347	-792,058	106,452,289	3,407,072.12	31.24	6.00
7.00	Total overhead cost (see instructions)	28,936,034	-15,301	28,920,733	1,455,396.81	19.87	7.00

Provider CCN: 140015	Period: From 10/01/2011 To 09/30/2012	Worksheet S-3 Part IV Date/Time Prepared: 2/28/2013 2:41 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	2,852,141	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	7,321,202	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)	18,176,438	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	127,277	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)	273,066	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	165,341	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	6,638,341	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	124,070	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	599,138	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	36,277,014	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

WAGE INDEX PENSION COST SCHEDULE

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

worksheet S-3
Part IV Exhibit 3
Date/Time Prepared:
2/28/2013 2:41 pm

		From	To	2016	
		1.00	2.00		1.00
Step 1: Determine the 3-Year Averaging Period					
1.00	Wage Index fiscal year ending.				1.00
2.00	Provider cost reporting period used for wage Index year shown on line 1.	10/01/2011	09/30/2012		2.00
3.00	Midpoint of provider's cost reporting period shown on line 2. (adjust response to first of month)	04/01/2012			3.00
4.00	Date beginning the 3-year averaging period. (subtract 18 months from midpoint shown on line 3)	10/01/2010			4.00
5.00	Date ending the of the 3-year averaging period. (add 18 months to midpoint shown on line 3)	09/30/2013			5.00
Step 2: Adjust Averaging Period for a New Plan(See Instructions) (Leave lines 6 through 8 blank if the provider has not elected to use an adjusted averaging period)					
6.00	Effective date of pension plan				6.00
7.00	First day of the provider cost reporting period containing the pension plan effective date.				7.00
8.00	Starting date of the adjusted averaging period. (date on line 7 if first of the month, otherwise to first of the month immediately preceding or following the date in line 7). If this date occurs after the period shown on line 2 (Step 1), stop here and see instructions. No cost is reportable for a period which is excluded from the averaging period.				8.00
Step 3: Average Pension Contribution During the Averaging Period					
9.00	Beginning date of averaging period from line 4 or line 8.	10/01/2010			9.00
10.00	Ending date of averaging period from line 5	09/30/2013			10.00
		Deposit Date	Contributions		
		1.00	2.00		
11.00	Enter provider contributions made during the averaging period shown on lines 9 & 10. Add additional lines as necessary if more than 15 contributions are made during the cost reporting period. (Data may be grouped within the averaging period to agree with documentation records (enter beginning date of grouped date range))				11.00
11.01				0	11.01
11.02				0	11.02
11.03				0	11.03
				1.00	
12.00	Total number of months included in the averaging period			36	12.00
13.00	Total contributions made during averaging period			0	13.00
14.00	Average monthly contribution. (line 13 divided by line 12)			0	14.00
15.00	Number of months in provider cost reporting period shown on line 2.			12	15.00
16.00	Average pension contributions. (line 14 multiplied by line 15)			0	16.00
Step 4: Total Pension Cost for Wage Index					
17.00	Annual prefunding installment from line 8 of pension prefunding worksheet, if applicable.			0	17.00
18.00	Reportable prefunding installment. (line 17 multiplied by line 15 divided by 12)			0	18.00
19.00	Total Pension Cost for Wage Index. (line 16 plus line 18)			0	19.00
		Prepared By	Date		
		1.00	2.00		
100.00	Prepared by and Date Prepared				100.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-3
Part V
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	2,731	0	1.00
2.00	Hospital	2,731	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 140015
Component CCN: 147031

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-4
Date/Time Prepared:
2/28/2013 2:41 pm

Home Health Agency I PPS

ADAMS 1.00

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

1.00	HOME HEALTH AGENCY STATISTICAL DATA							
	Home Health Aide Hours	0	7,699	0	1,864	9,563	1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	993.00	0.00	701.00	1,694.00	2.00	

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

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.98	0.00	0.98	4.00	4.00
5.00	Other Administrative Personnel		7.87	0.00	7.87	5.00	5.00
6.00	Direct Nursing Service		18.33	0.00	18.33	6.00	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00	7.00
8.00	Physical Therapy Service		6.01	0.00	6.01	8.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00	9.00
10.00	Occupational Therapy Service		2.21	0.00	2.21	10.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00	11.00
12.00	Speech Pathology Service		0.28	0.00	0.28	12.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00	13.00
14.00	Medical Social Service		1.58	0.00	1.58	14.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00	15.00
16.00	Home Health Aide		4.60	0.00	4.60	16.00	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00	18.00

HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		2				19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99914				20.00
20.01			99926				20.01

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

PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	12,112	2,390	307	132	14,941	21.00
22.00	Skilled Nursing Visit Charges	1,780,464	351,330	45,129	19,404	2,196,327	22.00
23.00	Physical Therapy Visits	6,040	185	51	93	6,369	23.00
24.00	Physical Therapy Visit Charges	887,880	27,195	7,497	13,671	936,243	24.00
25.00	Occupational Therapy Visits	1,862	70	9	50	1,991	25.00
26.00	Occupational Therapy Visit Charges	273,714	10,290	1,323	7,350	292,677	26.00
27.00	Speech Pathology Visits	228	20	0	0	248	27.00
28.00	Speech Pathology Visit Charges	33,516	2,940	0	0	36,456	28.00
29.00	Medical Social Service Visits	15	0	0	0	15	29.00
30.00	Medical Social Service Visit Charges	2,205	0	0	0	2,205	30.00
31.00	Home Health Aide Visits	2,876	1,372	3	16	4,267	31.00
32.00	Home Health Aide Visit Charges	235,832	112,504	246	1,312	349,894	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	23,133	4,037	370	291	27,831	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	3,213,611	504,259	54,195	41,737	3,813,802	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,200		132	24	1,356	36.00
37.00	Total Number of Outlier Episodes		64		0	64	37.00
38.00	Total Non-Routine Medical Supply Charges	26,570	17,059	780	528	44,937	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-7

Date/Time Prepared:
2/28/2013 2:41 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	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	50	0	50	5.00
6.00	RVL	13	0	13	6.00
7.00	RHX	253	0	253	7.00
8.00	RHL	226	0	226	8.00
9.00	RMX	51	0	51	9.00
10.00	RML	109	0	109	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	26	0	26	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	0	0	0	14.00
15.00	RVC	214	0	214	15.00
16.00	RVB	64	0	64	16.00
17.00	RVA	171	0	171	17.00
18.00	RHC	549	0	549	18.00
19.00	RHB	353	0	353	19.00
20.00	RHA	1,407	0	1,407	20.00
21.00	RMC	146	0	146	21.00
22.00	RMB	92	0	92	22.00
23.00	RMA	192	0	192	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	42	0	42	27.00
28.00	ES1	99	0	99	28.00
29.00	HE2	19	0	19	29.00
30.00	HE1	8	0	8	30.00
31.00	HD2	1	0	1	31.00
32.00	HD1	15	0	15	32.00
33.00	HC2	32	0	32	33.00
34.00	HC1	19	0	19	34.00
35.00	HB2	43	0	43	35.00
36.00	HB1	180	0	180	36.00
37.00	LE2	3	0	3	37.00
38.00	LE1	12	0	12	38.00
39.00	LD2	7	0	7	39.00
40.00	LD1	6	0	6	40.00
41.00	LC2	3	0	3	41.00
42.00	LC1	0	0	0	42.00
43.00	LB2	6	0	6	43.00
44.00	LB1	28	0	28	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	4	0	4	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	2	0	2	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	2	0	2	50.00
51.00	CB2	6	0	6	51.00
52.00	CB1	60	0	60	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	51	0	51	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: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-7

Date/Time Prepared:
2/28/2013 2:41 pm

	Group	SNF Days	Swing Bed Days	SNF	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00		
69.00	PE2	0	0	0	0	69.00
70.00	PE1	0	0	0	0	70.00
71.00	PD2	0	0	0	0	71.00
72.00	PD1	0	0	0	0	72.00
73.00	PC2	0	0	0	0	73.00
74.00	PC1	0	0	0	0	74.00
75.00	PB2	0	0	0	0	75.00
76.00	PB1	5	0	0	5	76.00
77.00	PA2	0	0	0	0	77.00
78.00	PA1	0	0	0	0	78.00
199.00	AAA	0	0	0	0	199.00
200.00	TOTAL		4,569	0	4,569	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

	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	1,399,044	31.45	Y	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)	4,448,743			207.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-7

Date/Time Prepared:
2/28/2013 2:41 pm

		1.00	2.00			1.00	2.00	3.00	4.00
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.								
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.								
		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	50	0	50	5.00			
6.00		RVL	13	0	13	6.00			
7.00		RHX	253	0	253	7.00			
8.00		RHL	226	0	226	8.00			
9.00		RMX	51	0	51	9.00			
10.00		RML	109	0	109	10.00			
11.00		RLX	0	0	0	11.00			
12.00		RUC	26	0	26	12.00			
13.00		RUB	0	0	0	13.00			
14.00		RUA	0	0	0	14.00			
15.00		RVC	214	0	214	15.00			
16.00		RVB	64	0	64	16.00			
17.00		RVA	171	0	171	17.00			
18.00		RHC	549	0	549	18.00			
19.00		RHB	353	0	353	19.00			
20.00		RHA	1,407	0	1,407	20.00			
21.00		RMC	146	0	146	21.00			
22.00		RMB	92	0	92	22.00			
23.00		RMA	192	0	192	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	42	0	42	27.00			
28.00		ES1	99	0	99	28.00			
29.00		HE2	19	0	19	29.00			
30.00		HE1	8	0	8	30.00			
31.00		HD2	1	0	1	31.00			
32.00		HD1	15	0	15	32.00			
33.00		HC2	32	0	32	33.00			
34.00		HC1	19	0	19	34.00			
35.00		HB2	43	0	43	35.00			
36.00		HB1	180	0	180	36.00			
37.00		LE2	3	0	3	37.00			
38.00		LE1	12	0	12	38.00			
39.00		LD2	7	0	7	39.00			
40.00		LD1	6	0	6	40.00			
41.00		LC2	3	0	3	41.00			
42.00		LC1	0	0	0	42.00			
43.00		LB2	6	0	6	43.00			
44.00		LB1	28	0	28	44.00			
45.00		CE2	0	0	0	45.00			
46.00		CE1	4	0	4	46.00			
47.00		CD2	0	0	0	47.00			
48.00		CD1	2	0	2	48.00			
49.00		CC2	0	0	0	49.00			
50.00		CC1	2	0	2	50.00			
51.00		CB2	6	0	6	51.00			
52.00		CB1	60	0	60	52.00			
53.00		CA2	0	0	0	53.00			
54.00		CA1	51	0	51	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: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-7

Date/Time Prepared:
2/28/2013 2:41 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	5	0	5	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		4,569	0	4,569	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	1,399,044	31.45	Y	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)	4,448,743			207.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140015 Component CCN: 143422	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/28/2013 2:41 pm	
		Rural Health Clinic (RHC) I		Cost	
				1.00	
1.00	Clinic Address and Identification	102 PRAIRIE MILLS ROAD		1.00	
	Street	City	State	Zip Code	
2.00	City, State, Zip Code, County	GOLDEN	IL	62339	2.00
				1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award	Date		
		1.00	2.00		
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0	5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0	6.00
7.00	Appalachian Regional Commission			0	7.00
8.00	Look-Alikes			0	8.00
9.00	OTHER (SPECIFY)			0	9.00
				1.00 2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
11.00	Facility hours of operations (1)	09:00		17:00	
				1.00 2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 104-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	Provider name, CCN number			14.00	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
				Total Visits	
				5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	N	0	0	0
				0 15.00	

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

Provider CCN: 140015
Component CCN: 143422

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-8
Date/Time Prepared:
2/28/2013 2:41 pm

				Rural Health Clinic (RHC) I	Cost
		County			
		4.00			
2.00	City, State, Zip Code, County	ADAMS		2.00	
		Tuesday		Wednesday	
		from	to	from	to
		5.00	6.00	7.00	8.00
11.00	Facility hours of operations (1) Clinic	09:00	17:00	09:00	17:00
					11.00

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

Provider CCN: 140015
Component CCN: 143422

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-8

Date/Time Prepared:
2/28/2013 2:41 pm

		Thursday		Friday		
		from	to	from	to	
Rural Health Clinic (RHC) I		9.00	10.00	11.00	12.00	Cost
11.00	Facility hours of operations (1) Clinic	09:00	17:00	09:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140015 Component CCN: 143422	Period: From 10/01/2011 To 09/30/2012	worksheet S-8 Date/Time Prepared: 2/28/2013 2:41 pm
			Rural Health Clinic (RHC) I	Cost
		Saturday		
		From	to	
		13:00	14:00	
11.00	Facility hours of operations (1) Clinic			11.00

		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
2.00	Routine Home Care	15,671	225	0	119	570
3.00	Inpatient Respite Care	24	0	0	0	0
4.00	General Inpatient Care	326	31	0	0	48
5.00	Total Hospice Days	16,021	256	0	119	618
PART II - CENSUS DATA						
6.00	Number of Patients Receiving Hospice Care	523	23	0	7	42
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00		
8.00	Average Length of Stay (line 5/line 6)	30.63	11.13	0.00	17.00	14.71
9.00	Unduplicated Census Count	510	23	0	8	42

Provider CCN: 140015
Component CCN: 141501

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-9
Parts I & II
Date/Time Prepared:
2/28/2013 2:41 pm

		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	16,466		2.00
3.00	Inpatient Respite Care	24		3.00
4.00	General Inpatient Care	405		4.00
5.00	Total Hospice Days	16,895		5.00
PART II - CENSUS DATA				
6.00	Number of Patients Receiving Hospice Care	588		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)	28.73		8.00
9.00	Unduplicated Census Count	575		9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140015	Period: From 10/01/2011 To 09/30/2012	Worksheet S-10 Date/Time Prepared: 2/28/2013 2:41 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.288259	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		15,057,530	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		6,478,682	5.00
6.00	Medicaid charges		88,690,298	6.00
7.00	Medicaid cost (line 1 times line 6)		25,565,777	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		4,029,565	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)		4,029,565	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	26,770,644	37,135,567	63,906,211
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	7,716,879	10,704,661	18,421,540
22.00	Partial payment by patients approved for charity care	61,001	2,702,816	2,763,817
23.00	Cost of charity care (line 21 minus line 22)	7,655,878	8,001,845	15,657,723
				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)		23,089,158	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		1,365,076	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		21,724,082	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		6,262,162	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		21,919,885	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		25,949,450	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet A

Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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	00100		0	0	0	0	1.00
1.01	00101		5,020	5,020	22,884	27,904	1.01
1.02	00102		235,390	235,390	43,955	279,345	1.02
1.03	00103		3,090,325	3,090,325	473,564	3,563,889	1.03
1.04	00104		309,692	309,692	1,336,606	1,646,298	1.04
1.05	00105				225,716	225,716	1.05
2.00	00200		9,998,565	9,998,565	507,279	10,505,844	2.00
3.00	00300						3.00
4.00	00400	2,361,505	37,793,770	40,155,275		40,155,275	4.00
5.00	00500	12,963,165	51,535,221	64,498,386	333,953	64,832,339	5.00
6.00	00600	2,351,700	3,640,897	5,992,597		5,992,597	6.00
8.00	00800	64,383	968,346	1,032,729		1,032,729	8.00
9.00	00900	2,061,643	405,799	2,467,442		2,467,442	9.00
10.00	01000	2,141,400	2,670,301	4,811,701	-3,303,714	1,507,987	10.00
11.00	01100				3,303,714	3,303,714	11.00
13.00	01300	5,270,173	927,528	6,197,701	-15,347	6,182,354	13.00
16.00	01600	1,722,065	880,995	2,603,060		2,603,060	16.00
20.00	02000	2,507,907	1,107,363	3,615,270	834,161	4,449,431	20.00
21.00	02100	1,033,081		1,033,081		1,033,081	21.00
22.00	02200		1,514,899	1,514,899		1,514,899	22.00
23.00	02300						23.00
23.01	02301	225,390	4,765	230,155		230,155	23.01
23.02	02302	74,774	724	75,498		75,498	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	13,970,923	1,112,228	15,083,151	-549,663	14,533,488	30.00
31.00	03100	3,778,276	459,955	4,238,231	-283,233	3,954,998	31.00
40.00	04000	3,520,894	89,928	3,610,822	-46,694	3,564,128	40.00
41.00	04100	1,475,486	257,428	1,732,914	-13,930	1,718,984	41.00
43.00	04300	455,107	70,487	525,594	-77,980	447,614	43.00
44.00	04400	1,399,044	123,634	1,522,678	-29,069	1,493,609	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	7,659,873	15,625,244	23,285,117	-11,302,800	11,982,317	50.00
52.00	05200	1,192,051	224,254	1,416,305	-90,693	1,325,612	52.00
53.00	05300	181,172	444,298	625,470	-162,604	462,866	53.00
54.00	05400	4,762,220	3,209,721	7,971,941	-309,811	7,662,130	54.00
60.00	06000	3,021,510	2,606,613	5,628,123	-40,211	5,587,912	60.00
62.00	06200	185,447	1,143,527	1,328,974		1,328,974	62.00
65.00	06500	1,881,334	354,974	2,236,308	-92,031	2,144,277	65.00
66.00	06600	1,573,324	212,983	1,786,307	-12,556	1,773,751	66.00
67.00	06700	578,588	9,803	588,391	-1,661	586,730	67.00
68.00	06800	271,070	8,913	279,983	-2,004	277,979	68.00
69.00	06900	1,423,506	3,337,822	4,761,328	-2,636,706	2,124,622	69.00
70.00	07000	291,702	73,326	365,028		365,028	70.00
71.00	07100	685,369	434,232	1,119,601	5,559,925	6,679,526	71.00
72.00	07200				9,207,245	9,207,245	72.00
73.00	07300	3,046,304	14,247,391	17,293,695	-82	17,293,613	73.00
74.00	07400		741,158	741,158	-495	740,663	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	358,399	431,280	789,679	-2,293	787,386	88.00
91.00	09100	10,290,236	1,359,741	11,649,977	-119,546	11,530,431	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	2,826,665	1,027,431	3,854,096	-1,155	3,852,941	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		2,770,041	2,770,041	-2,770,041	0	113.00
116.00	11600	1,602,036	573,163	2,175,199	-30	2,175,169	116.00
118.00		99,207,722	166,039,175	265,246,897	-15,347	265,231,550	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000						190.00
192.00	19200	2,815,383	104,783	2,920,166		2,920,166	192.00
192.01	19201	413,528	102,407	515,935		515,935	192.01
193.00	19300						193.00
193.01	19301						193.01
193.02	19302						193.02
193.03	19303						193.03
193.04	19304						193.04
193.05	19305				15,347	15,347	193.05
193.06	19306						193.06
193.07	19307	161,741	780,754	942,495		942,495	193.07
200.00		102,598,374	167,027,119	269,625,493		269,625,493	200.00

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	0	27,904	1.01
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT	0	279,345	1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT	86,601	3,650,490	1.03
1.04	00104	CAP REL COSTS-14TH STREET	-850,222	796,076	1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	-170,749	54,967	1.05
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-368,375	10,137,469	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	-16,300,505	23,854,770	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-26,757,969	38,074,370	5.00
6.00	00600	MAINTENANCE & REPAIRS	-575,775	5,416,822	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	-20,363	1,012,366	8.00
9.00	00900	HOUSEKEEPING	-241,590	2,225,852	9.00
10.00	01000	DIETARY	-111,942	1,396,045	10.00
11.00	01100	CAFETERIA	-1,297,910	2,005,804	11.00
13.00	01300	NURSING ADMINISTRATION	-174,724	6,007,630	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-112,440	2,490,620	16.00
20.00	02000	NURSING SCHOOL	-2,924,068	1,525,363	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,033,081	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,514,899	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	-77,791	152,364	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	-22,828	52,670	23.02
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-5,692	14,527,796	30.00
31.00	03100	INTENSIVE CARE UNIT	-18,524	3,936,474	31.00
40.00	04000	SUBPROVIDER - IPF	0	3,564,128	40.00
41.00	04100	SUBPROVIDER - IRF	-15,718	1,703,266	41.00
43.00	04300	NURSERY	0	447,614	43.00
44.00	04400	SKILLED NURSING FACILITY	-482	1,493,127	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-937,726	11,044,591	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,325,612	52.00
53.00	05300	ANESTHESIOLOGY	0	462,866	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,662,130	54.00
60.00	06000	LABORATORY	-65,585	5,522,327	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,328,974	62.00
65.00	06500	RESPIRATORY THERAPY	-17,683	2,126,594	65.00
66.00	06600	PHYSICAL THERAPY	-15,595	1,758,156	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	586,730	67.00
68.00	06800	SPEECH PATHOLOGY	0	277,979	68.00
69.00	06900	ELECTROCARDIOLOGY	-33,472	2,091,150	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-38,507	326,521	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-2,231	6,677,295	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,207,245	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,311,160	14,982,453	73.00
74.00	07400	RENAL DIALYSIS	0	740,663	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-38,835	748,551	88.00
91.00	09100	EMERGENCY	-6,592,698	4,937,733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	3,852,941	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	-29,065	2,146,104	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-60,043,623	205,187,927	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,920,166	192.00
192.01	19201	FASTCARE	0	515,935	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	ADULT DAY CARE	0	0	193.01
193.02	19302	DENMAN SERVICES	0	0	193.02
193.03	19303	MEALS ON WHEELS	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	193.04
193.05	19305	HEALTH EDUCATION	0	15,347	193.05
193.06	19306	RENTED SPACE	0	0	193.06
193.07	19307	AUGUSTA PHARMACY	0	942,495	193.07
200.00		TOTAL (SUM OF LINES 118-199)	-60,043,623	209,581,870	200.00

	Increases				
	Cost Center 2.00	Line # 3.00	Salary 4.00	Other 5.00	
A - RECLASS CAFETERIA COST					
1.00	CAFETERIA	11.00	1,470,285	1,833,429	1.00
	TOTALS		1,470,285	1,833,429	
B - RECLASS C-SECTION COSTS					
1.00	OPERATING ROOM	50.00	5,724	0	1.00
	TOTALS		5,724	0	
D - RECLASS CAPITAL RELATED INSURANCE					
1.00	CAP REL COSTS-BUTLER BUILDING	1.01	0	22,884	1.00
2.00	CAP REL COSTS-OLD BUILDING & FIXT	1.02	0	43,955	2.00
3.00	CAP REL COSTS-NEW BUILDING & FIXT	1.03	0	63,490	3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,707	4.00
	TOTALS		0	136,036	
F - RECLASS HEALTH EDUCATION					
1.00	HEALTH EDUCATION	193.05	15,301	46	1.00
	TOTALS		15,301	46	
G - RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-NEW BUILDING & FIXT	1.03	0	410,074	1.00
2.00	CAP REL COSTS-14TH STREET	1.04	0	1,336,606	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	501,572	3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	521,789	4.00
	TOTALS		0	2,770,041	
H - RECLASS ER PHYSICIAN MALPRACTICE INS					
1.00	EMERGENCY	91.00	0	51,800	1.00
	TOTALS		0	51,800	
I - RECLASS CHARGEABLE MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,559,925	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,207,245	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
	TOTALS		0	14,767,170	
J - RECLASS PRECEPTOR PAY					
1.00	NURSING SCHOOL	20.00	834,161	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
	TOTALS		834,161	0	
K - RECLASS RENT EXPENS					
1.00	CAP REL COSTS-MOB PHASE I	1.05	0	225,716	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	225,716	
500.00	Grand Total: Increases		2,325,471	19,784,238	500.00

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - RECLASS CAFETERIA COST						
1.00	DIETARY	10.00	1,470,285	1,833,429	0	1.00
	TOTALS		1,470,285	1,833,429		
B - RECLASS C-SECTION COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	5,724	0	0	1.00
	TOTALS		5,724	0		
D - RECLASS CAPITAL RELATED INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	136,036	12	1.00
2.00		0.00	0	0	12	2.00
3.00		0.00	0	0	12	3.00
4.00		0.00	0	0	12	4.00
	TOTALS		0	136,036		
F - RECLASS HEALTH EDUCATION						
1.00	NURSING ADMINISTRATION	13.00	15,301	46	0	1.00
	TOTALS		15,301	46		
G - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	2,770,041	11	1.00
2.00		0.00	0	0	11	2.00
3.00		0.00	0	0	11	3.00
4.00		0.00	0	0	11	4.00
	TOTALS		0	2,770,041		
H - RECLASS ER PHYSICIAN MALPRACTICE INS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	51,800	0	1.00
	TOTALS		0	51,800		
I - RECLASS CHARGEABLE MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	180,964	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	153,548	0	2.00
3.00	SUBPROVIDER - IPF	40.00	0	1,256	0	3.00
4.00	SUBPROVIDER - IRF	41.00	0	11,328	0	4.00
5.00	NURSERY	43.00	0	36,119	0	5.00
6.00	SKILLED NURSING FACILITY	44.00	0	19,705	0	6.00
7.00	OPERATING ROOM	50.00	0	11,053,184	0	7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	65,649	0	8.00
9.00	ANESTHESIOLOGY	53.00	0	162,604	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	239,565	0	10.00
11.00	LABORATORY	60.00	0	40,211	0	11.00
12.00	RESPIRATORY THERAPY	65.00	0	92,031	0	12.00
13.00	PHYSICAL THERAPY	66.00	0	12,556	0	13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	1,661	0	14.00
15.00	SPEECH PATHOLOGY	68.00	0	2,004	0	15.00
16.00	ELECTROCARDIOLOGY	69.00	0	2,600,390	0	16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	82	0	17.00
18.00	RENAL DIALYSIS	74.00	0	495	0	18.00
19.00	RURAL HEALTH CLINIC	88.00	0	2,293	0	19.00
20.00	EMERGENCY	91.00	0	90,254	0	20.00
21.00	ADULTS & PEDIATRICS	30.00	0	86	0	21.00
22.00	HOME HEALTH AGENCY	101.00	0	1,155	0	22.00
23.00	HOSPICE	116.00	0	30	0	23.00
	TOTALS		0	14,767,170		
J - RECLASS PRECEPTOR PAY						
1.00	ADULTS & PEDIATRICS	30.00	317,714	0	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	49,856	0	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	129,685	0	0	3.00
4.00	SUBPROVIDER - IPF	40.00	45,438	0	0	4.00
5.00	SUBPROVIDER - IRF	41.00	2,602	0	0	5.00
6.00	NURSERY	43.00	41,861	0	0	6.00
7.00	SKILLED NURSING FACILITY	44.00	9,364	0	0	7.00
8.00	OPERATING ROOM	50.00	99,870	0	0	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	19,320	0	0	9.00
10.00	ELECTROCARDIOLOGY	69.00	36,316	0	0	10.00
11.00	EMERGENCY	91.00	81,092	0	0	11.00
12.00	ADULTS & PEDIATRICS	30.00	1,043	0	0	12.00
	TOTALS		834,161	0		
K - RECLASS RENT EXPENS						
1.00	OPERATING ROOM	50.00	0	155,470	10	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	70,246	10	2.00
	TOTALS		0	225,716		
500.00	Grand Total: Decreases		2,325,471	19,784,238		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/28/2013 2:41 pm

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
	1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	12,708,356	155,500	0	155,500	0	1.00
2.00	Land Improvements	5,697,771	711,023	0	711,023	0	2.00
3.00	Buildings and Fixtures	96,177,101	1,474,477	0	1,474,477	170,675	3.00
4.00	Building Improvements	3,564,673	0	0	0	0	4.00
5.00	Fixed Equipment	35,413,331	969,610	0	969,610	0	5.00
6.00	Movable Equipment	122,766,017	12,805,591	0	12,805,591	1,696,987	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	276,327,249	16,116,201	0	16,116,201	1,867,662	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	276,327,249	16,116,201	0	16,116,201	1,867,662	10.00
SUMMARY OF CAPITAL							
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
	9.00	10.00	11.00	12.00	13.00		
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	5,020	0	0	0	0	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	235,390	0	0	0	0	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	3,090,325	0	0	0	0	1.03
1.04	CAP REL COSTS-14TH STREET	309,692	0	0	0	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	0	1.05
2.00	CAP REL COSTS-MVBLE EQUIP	9,998,565	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	13,638,992	0	0	0	0	3.00
COMPUTATION OF RATIOS							
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	307,247	0	307,247	0.001132	0	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	86,039,885	0	86,039,885	0.317136	0	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	35,217,887	0	35,217,887	0.129810	0	1.03
1.04	CAP REL COSTS-14TH STREET	15,863,498	0	15,863,498	0.058471	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0.000000	0	1.05
2.00	CAP REL COSTS-MVBLE EQUIP	133,874,622	0	133,874,622	0.493451	0	2.00
3.00	Total (sum of lines 1-2)	271,303,139	0	271,303,139	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/28/2013 2:41 pm

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	12,863,856	0			1.00
2.00	Land Improvements	6,408,794	0			2.00
3.00	Buildings and Fixtures	97,480,903	0			3.00
4.00	Building Improvements	3,564,673	0			4.00
5.00	Fixed Equipment	36,382,941	0			5.00
6.00	Movable Equipment	133,874,621	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	290,575,788	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	290,575,788	0			10.00
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0			1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	5,020			1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	0	235,390			1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	0	3,090,325			1.03
1.04	CAP REL COSTS-14TH STREET	0	309,692			1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0			1.05
2.00	CAP REL COSTS-MVBLE EQUIP	0	9,998,565			2.00
3.00	Total (sum of lines 1-2)	0	13,638,992			3.00
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	0	0	5,020	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	0	0	0	235,390	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	0	0	0	3,015,287	1.03
1.04	CAP REL COSTS-14TH STREET	0	0	0	306,601	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	54,967
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	9,932,936	0
3.00	Total (sum of lines 1-2)	0	0	0	13,495,234	54,967

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
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Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see Instructions)	Taxes (see Instructions)	Other Capital-Related Costs (see Instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	22,884	0	0	27,904	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	0	43,955	0	0	279,345	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	571,713	63,490	0	0	3,650,490	1.03
1.04	CAP REL COSTS-14TH STREET	489,475	0	0	0	796,076	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	54,967	1.05
2.00	CAP REL COSTS-MVBLE EQUIP	198,826	5,707	0	0	10,137,469	2.00
3.00	Total (sum of lines 1-2)	1,260,014	136,036	0	0	14,946,251	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #		
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	1.00
1.01 Investment income - CAP REL COSTS-BUTLER BUILDING (chapter 2)			0	CAP REL COSTS-BUTLER BUILDING	1.01	1.01
1.02 Investment income - CAP REL COSTS-OLD BUILDING & FIXT (chapter 2)			0	CAP REL COSTS-OLD BUILDING & FIXT	1.02	1.02
1.03 Investment income - CAP REL COSTS-NEW BUILDING & FIXT (chapter 2)			0	CAP REL COSTS-NEW BUILDING & FIXT	1.03	1.03
1.04 Investment income - CAP REL COSTS-14TH STREET (chapter 2)			0	CAP REL COSTS-14TH STREET	1.04	1.04
1.05 Investment income - CAP REL COSTS-MOB PHASE I (chapter 2)			0	CAP REL COSTS-MOB PHASE I	1.05	1.05
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00 Investment income - other (chapter 2)			0		0.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-414,022		ADMINISTRATIVE & GENERAL	5.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-155,955		ADMINISTRATIVE & GENERAL	5.00	7.00
8.00 Television and radio service (chapter 21)	A	-20,261		CAP REL COSTS-MVBLE EQUIP	2.00	8.00
9.00 Parking lot (chapter 21)			0		0.00	9.00
10.00 Provider-based physician adjustment	A-8-2	-18,870,975				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	-1,345,935				12.00
13.00 Laundry and linen service			0		0.00	13.00
14.00 Cafeteria-employees and guests	B	-1,297,910		CAFETERIA	11.00	14.00
15.00 Rental of quarters to employee and others			0		0.00	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	16.00
17.00 Sale of drugs to other than patients	A	-2,249,435		DRUGS CHARGED TO PATIENTS	73.00	17.00
18.00 Sale of medical records and abstracts	B	-12,721		MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)	B	-2,902,774		NURSING SCHOOL	20.00	19.00
20.00 Vending machines	B	-81,328		DIETARY	10.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	26.00
26.01 Depreciation - CAP REL COSTS-BUTLER BUILDING			0	CAP REL COSTS-BUTLER BUILDING	1.01	26.01
26.02 Depreciation - CAP REL COSTS-OLD BUILDING & FIXT			0	CAP REL COSTS-OLD BUILDING & FIXT	1.02	26.02
26.03 Depreciation - CAP REL COSTS-NEW BUILDING & FIXT			0	CAP REL COSTS-NEW BUILDING & FIXT	1.03	26.03
26.04 Depreciation - CAP REL COSTS-14TH STREET			0	CAP REL COSTS-14TH STREET	1.04	26.04
26.05 Depreciation - CAP REL COSTS-MOB PHASE I			0	CAP REL COSTS-MOB PHASE I	1.05	26.05
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant			0		0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	32.00
33.00 RENTAL INSURANCE EXPENSE	A	-9,210		ADMINISTRATIVE & GENERAL	5.00	33.00
33.01 DAMAGED GOODS	B	-14,742		ADMINISTRATIVE & GENERAL	5.00	33.01
33.02 CHILD CARE CENTER	B	-1,674,835		EMPLOYEE BENEFITS	4.00	33.02
33.03 GUEST TRAYS	B	-2,090		DIETARY	10.00	33.03

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-8

Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description	Basts/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
			Cost Center	Line #
			1.00	2.00
33.04 BOOKKEEPING FEES	B	-120,366	ADMINISTRATIVE & GENERAL	5.00 33.04
33.05 RADIOLOGY TUITION	B	-77,791	PARAMED ED PRGM-RADIOLOGY	23.01 33.05
33.06 PRINT SHOP	B	-63,234	ADMINISTRATIVE & GENERAL	5.00 33.06
33.07 HEALTH PROMOTIONS	B	-171,899	NURSING ADMINISTRATION	13.00 33.07
33.08 HOUSEKEEPING SERVICES	B	-241,590	HOUSEKEEPING	9.00 33.08
33.09 ADVERTISING	A	-317,526	ADMINISTRATIVE & GENERAL	5.00 33.09
33.10 RENTAL PROPERTY EXPENSE	A	-155,118	CAP REL COSTS-NEW BUILDING & FIXT	1.03 33.10
33.11 RENTAL PROPERTY EXPENSE	A	-2,786	CAP REL COSTS-MVBLE EQUIP	2.00 33.11
33.12 REAL ESTATE TAXES ON RENTAL	A	-70,726	MAINTENANCE & REPAIRS	6.00 33.12
33.13 RENTAL PROPERTY EXPENSE	A	-67,744	MAINTENANCE & REPAIRS	6.00 33.13
33.14 DIETARY CONSULT AUTOS	A	-4,443	CAP REL COSTS-MVBLE EQUIP	2.00 33.14
33.15 INTEREST INCOME	A	-213,688	CAP REL COSTS-NEW BUILDING & FIXT	1.03 33.15
33.16 INTEREST INCOME	A	-847,131	CAP REL COSTS-14TH STREET	1.04 33.16
33.17 INTEREST INCOME	A	-302,746	CAP REL COSTS-MVBLE EQUIP	2.00 33.17
33.18 INTEREST INCOME	A	-271,902	ADMINISTRATIVE & GENERAL	5.00 33.18
33.19 DIETARY OUTSIDE SERVICES-SALARIES	A	-28,524	DIETARY	10.00 33.19
33.20 DIETARY OUTSIDE SERVICES-BENEFITS	A	-10,115	EMPLOYEE BENEFITS	4.00 33.20
33.21 PHYSICIAN RECRUITMENT	A	-432,323	ADMINISTRATIVE & GENERAL	5.00 33.21
33.22 NURSING SCHOOL ADVERTISING	A	-21,294	NURSING SCHOOL	20.00 33.22
33.23 LOBBYING EXPENSE	A	-31,405	ADMINISTRATIVE & GENERAL	5.00 33.23
33.24 TRANSFER TO PARENT	A	-1,623,072	ADMINISTRATIVE & GENERAL	5.00 33.24
33.25 HOSPICE PROFESSIONAL FEES	A	-29,065	HOSPICE	116.00 33.25
33.26 ER PHYSICIAN BENEFITS	A	-740,358	EMPLOYEE BENEFITS	4.00 33.26
33.27 ALCOHOL RELATED EXPENSES	A	-3,000	ADMINISTRATIVE & GENERAL	5.00 33.27
33.28 BOOK TO MEDICARE DEPRECIATION	A	80,080	CAP REL COSTS-NEW BUILDING & FIXT	1.03 33.28
33.29 BOOK TO MEDICARE DEPRECIATION	A	34,313	CAP REL COSTS-MVBLE EQUIP	2.00 33.29
33.30 GROUND FEES	B	-60,705	MAINTENANCE & REPAIRS	6.00 33.30
33.31 LABORATORY TUITION	B	-22,828	PARAMED ED PRGM-LABORATORY	23.02 33.31
33.32 CV SURGEON BENEFITS	A	-74,297	EMPLOYEE BENEFITS	4.00 33.32
33.33 ILLINI ER PHYSICIAN BENEFITS	A	-106,305	EMPLOYEE BENEFITS	4.00 33.33
33.34 SELF-FUNDED HEALTH INSURANCE	A	-12,361,006	EMPLOYEE BENEFITS	4.00 33.34
33.35 LEASED EQUIPMENT	B	-3,122	CAP REL COSTS-MVBLE EQUIP	2.00 33.35
33.36 STUDER GROUP EXPENSE	A	-333,494	ADMINISTRATIVE & GENERAL	5.00 33.36
33.37 TRAUMA ON-CALL	A	-672,320	ADMINISTRATIVE & GENERAL	5.00 33.37
33.38 NON-HOSPITAL DEPRECIATION	A	-69,330	CAP REL COSTS-MVBLE EQUIP	2.00 33.38
33.39 LOSS ON EARLY EXTINGUISHMENT OF DEBT	A	375,327	CAP REL COSTS-NEW BUILDING & FIXT	1.03 33.39
33.40 MISCELLANEOUS INCOME	B	-62,865	ADMINISTRATIVE & GENERAL	5.00 33.40
33.41 MISCELLANEOUS INCOME	B	-5,545	LABORATORY	60.00 33.41
33.42 MISCELLANEOUS INCOME	B	-15,595	PHYSICAL THERAPY	66.00 33.42
33.43 MISCELLANEOUS INCOME	B	-2,283	OPERATING ROOM	50.00 33.43
33.44 MISCELLANEOUS INCOME	B	-7,145	RESPIRATORY THERAPY	65.00 33.44
33.45 MISCELLANEOUS INCOME	B	-31,054	ELECTROENCEPHALOGRAPHY	70.00 33.45
33.46 MISCELLANEOUS INCOME	B	-190	ADMINISTRATIVE & GENERAL	5.00 33.46
33.47 MISCELLANEOUS INCOME	B	-18,784	ADMINISTRATIVE & GENERAL	5.00 33.47
33.48 MISCELLANEOUS INCOME	B	-509,280	ADMINISTRATIVE & GENERAL	5.00 33.48
33.49 MISCELLANEOUS INCOME	B	-3,091	CAP REL COSTS-14TH STREET	1.04 33.49
33.50 MISCELLANEOUS INCOME	B	-2,825	NURSING ADMINISTRATION	13.00 33.50
33.51 MISCELLANEOUS INCOME	B	-2,231	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00 33.51
33.52 MISCELLANEOUS INCOME	B	-40	LABORATORY	60.00 33.52
33.53 MISCELLANEOUS INCOME	B	-9,424	ELECTROCARDIOLOGY	69.00 33.53
33.54 MISCELLANEOUS INCOME	B	-2,179	MEDICAL RECORDS & LIBRARY	16.00 33.54
33.55 MISCELLANEOUS INCOME	B	-94,442	ADMINISTRATIVE & GENERAL	5.00 33.55
33.56 BPS EXPENSES	A	-10,668,087	ADMINISTRATIVE & GENERAL	5.00 33.56
33.57 ECHO OUTREACH SALARIES	A	-12,683	ELECTROCARDIOLOGY	69.00 33.57
33.58 ECHO OUTREACH BENEFITS	A	-4,496	EMPLOYEE BENEFITS	4.00 33.58
33.59 PHARMACY COVERAGE SALARIES	A	-40,709	DRUGS CHARGED TO PATIENTS	73.00 33.59
33.60 PHARMACY COVERAGE BENEFITS	A	-14,435	EMPLOYEE BENEFITS	4.00 33.60
33.61 PHARMACY COVERAGE EXPENSES	A	-21,016	DRUGS CHARGED TO PATIENTS	73.00 33.61
33.62 MEDICAL RECORDS SALARIES	A	-64,503	MEDICAL RECORDS & LIBRARY	16.00 33.62
33.63 MEDICAL RECORDS BENEFITS	A	-22,873	EMPLOYEE BENEFITS	4.00 33.63
33.64 MEDICAL RECORDS EXPENSES	A	-33,037	MEDICAL RECORDS & LIBRARY	16.00 33.64
33.65 PAIN MANAGEMENT NP SALARIES	A	-50,567	OPERATING ROOM	50.00 33.65
33.66 PAIN MANAGEMENT NP BENEFITS	A	-17,931	EMPLOYEE BENEFITS	4.00 33.66
33.67 PAIN MANAGEMENT NP EXPENSES	A	-900	OPERATING ROOM	50.00 33.67

Provider CCN: 140015

Period:
 From 10/01/2011
 To 09/30/2012

Worksheet A-8
 Date/Time Prepared:
 2/28/2013 2:41 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted		Line #	
				Cost Center	Line #		
33.68	NP AND PA IN URGENT CARE SALARIES	A	-156,273	EMERGENCY	3.00	91.00	33.68
33.69	NP AND PA IN URGENT CARE BENEFITS	A	-55,414	EMPLOYEE BENEFITS	3.00	4.00	33.69
33.70			0			0.00	33.70
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-60,043,623				50.00

Cost Center	Description	Wkst.	A-7	Ref.	
		5.00			
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	1.00
1.01	Investment income - CAP REL COSTS-BUTLER BUILDING (chapter 2)			0	1.01
1.02	Investment income - CAP REL COSTS-OLD BUILDING & FIXT (chapter 2)			0	1.02
1.03	Investment income - CAP REL COSTS-NEW BUILDING & FIXT (chapter 2)			0	1.03
1.04	Investment income - CAP REL COSTS-14TH STREET (chapter 2)			0	1.04
1.05	Investment income - CAP REL COSTS-MOB PHASE I (chapter 2)			0	1.05
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	2.00
3.00	Investment income - other (chapter 2)			0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			0	7.00
8.00	Television and radio service (chapter 21)			9	8.00
9.00	Parking lot (chapter 21)			0	9.00
10.00	Provider-based physician adjustment			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)			0	11.00
12.00	Related organization transactions (chapter 10)			0	12.00
13.00	Laundry and linen service			0	13.00
14.00	Cafeteria-employees and guests			0	14.00
15.00	Rental of quarters to employee and others			0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0	16.00
17.00	Sale of drugs to other than patients			0	17.00
18.00	Sale of medical records and abstracts			0	18.00
19.00	Nursing school (tuition, fees, books, etc.)			0	19.00
20.00	Vending machines			0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)				23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)				24.00
25.00	Utilization review - physicians' compensation (chapter 21)				25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0	26.00
26.01	Depreciation - CAP REL COSTS-BUTLER BUILDING			0	26.01
26.02	Depreciation - CAP REL COSTS-OLD BUILDING & FIXT			0	26.02
26.03	Depreciation - CAP REL COSTS-NEW BUILDING & FIXT			0	26.03
26.04	Depreciation - CAP REL COSTS-14TH STREET			0	26.04
26.05	Depreciation - CAP REL COSTS-MOB PHASE I			0	26.05
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0	27.00
28.00	Non-physician Anesthetist				28.00
29.00	Physicians' assistant			0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)				30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)				31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	32.00
33.00	RENTAL INSURANCE EXPENSE			0	33.00
33.01	DAMAGED GOODS			0	33.01
33.02	CHILD CARE CENTER			0	33.02
33.03	GUEST TRAYS			0	33.03
33.04	BOOKKEEPING FEES			0	33.04
33.05	RADIOLOGY TUITION			0	33.05
33.06	PRINT SHOP			0	33.06
33.07	HEALTH PROMOTIONS			0	33.07
33.08	HOUSEKEEPING SERVICES			0	33.08
33.09	ADVERTISING			0	33.09
33.10	RENTAL PROPERTY EXPENSE			9	33.10

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-8

Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description	Wkst. A-7 Ref.		
	5.00		
33.11 RENTAL PROPERTY EXPENSE	9		33.11
33.12 REAL ESTATE TAXES ON RENTAL	0		33.12
33.13 RENTAL PROPERTY EXPENSE	0		33.13
33.14 DIETARY CONSULT AUTOS	9		33.14
33.15 INTEREST INCOME	11		33.15
33.16 INTEREST INCOME	11		33.16
33.17 INTEREST INCOME	11		33.17
33.18 INTEREST INCOME	0		33.18
33.19 DIETARY OUTSIDE SERVICES-SALARIES	0		33.19
33.20 DIETARY OUTSIDE SERVICES-BENEFITS	0		33.20
33.21 PHYSICIAN RECRUITMENT	0		33.21
33.22 NURSING SCHOOL ADVERTISING	0		33.22
33.23 LOBBYING EXPENSE	0		33.23
33.24 TRANSFER TO PARENT	0		33.24
33.25 HOSPICE PROFESSIONAL FEES	0		33.25
33.26 ER PHYSICIAN BENEFITS	0		33.26
33.27 ALCOHOL RELATED EXPENSES	0		33.27
33.28 BOOK TO MEDICARE DEPRECIATION	9		33.28
33.29 BOOK TO MEDICARE DEPRECIATION	9		33.29
33.30 GROUND FEES	0		33.30
33.31 LABORATORY TUITION	0		33.31
33.32 CV SURGEON BENEFITS	0		33.32
33.33 ILLINI ER PHYSICIAN BENEFITS	0		33.33
33.34 SELF-FUNDED HEALTH INSURANCE	0		33.34
33.35 LEASED EQUIPMENT	9		33.35
33.36 STUDER GROUP EXPENSE	0		33.36
33.37 TRAUMA ON-CALL	0		33.37
33.38 NON-HOSPITAL DEPRECIATION	9		33.38
33.39 LOSS ON EARLY EXTINGUISHMENT OF DEBT	11		33.39
33.40 MISCELLANEOUS INCOME	0		33.40
33.41 MISCELLANEOUS INCOME	0		33.41
33.42 MISCELLANEOUS INCOME	0		33.42
33.43 MISCELLANEOUS INCOME	0		33.43
33.44 MISCELLANEOUS INCOME	0		33.44
33.45 MISCELLANEOUS INCOME	0		33.45
33.46 MISCELLANEOUS INCOME	0		33.46
33.47 MISCELLANEOUS INCOME	0		33.47
33.48 MISCELLANEOUS INCOME	0		33.48
33.49 MISCELLANEOUS INCOME	9		33.49
33.50 MISCELLANEOUS INCOME	0		33.50
33.51 MISCELLANEOUS INCOME	0		33.51
33.52 MISCELLANEOUS INCOME	0		33.52
33.53 MISCELLANEOUS INCOME	0		33.53
33.54 MISCELLANEOUS INCOME	0		33.54
33.55 MISCELLANEOUS INCOME	0		33.55
33.56 BPS EXPENSES	0		33.56
33.57 ECHO OUTREACH SALARIES	0		33.57
33.58 ECHO OUTREACH BENEFITS	0		33.58
33.59 PHARMACY COVERAGE SALARIES	0		33.59
33.60 PHARMACY COVERAGE BENEFITS	0		33.60
33.61 PHARMACY COVERAGE EXPENSES	0		33.61
33.62 MEDICAL RECORDS SALARIES	0		33.62
33.63 MEDICAL RECORDS BENEFITS	0		33.63
33.64 MEDICAL RECORDS EXPENSES	0		33.64
33.65 PAIN MANAGEMENT NP SALARIES	0		33.65
33.66 PAIN MANAGEMENT NP BENEFITS	0		33.66
33.67 PAIN MANAGEMENT NP EXPENSES	0		33.67
33.68 NP AND PA IN URGENT CARE SALARIES	0		33.68
33.69 NP AND PA IN URGENT CARE BENEFITS	0		33.69
33.70	0		33.70
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: 140015

Period:
From 10/01/2011
To 09/30/2012

worksheet A-8-1
Date/Time Prepared:
2/28/2013 2:41 pm

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	6.00	MAINTENANCE & REPAIRS	BIO-MED 1.00
2.00	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY 2.00
3.00	88.00	RURAL HEALTH CLINIC	EAST ADAMS RENT 3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE 4.00
4.01	4.00	EMPLOYEE BENEFITS	BCS BENEFITS 4.01
4.02	1.05	CAP REL COSTS-MOB PHASE I	SURGERY RENT 4.02
4.03	1.05	CAP REL COSTS-MOB PHASE I	RADIOLOGY RENT 4.03
4.04	1.05	CAP REL COSTS-MOB PHASE I	WOUND RENT 4.04
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	G		0.00	6.00
7.00	G		0.00	7.00
8.00	G		0.00	8.00
9.00	B		0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:	BROTHER/SISTER		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: 140015

Period: From 10/01/2011 To 09/30/2012

Worksheet A-8-1

Date/Time Prepared: 2/28/2013 2:41 pm

	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	464,400	841,000	-376,600	0	1.00
2.00	918,029	938,392	-20,363	0	2.00
3.00	32,116	70,951	-38,835	0	3.00
4.00	6,606,190	6,140,051	466,139	0	4.00
4.01	-1,205,527	0	-1,205,527	0	4.01
4.02	16,789	68,573	-51,784	10	4.02
4.03	16,903	70,246	-53,343	10	4.03
4.04	21,275	86,897	-65,622	10	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	6,870,175	8,216,110	-1,345,935	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	DENMAN SERVICES	0.00	BIO-MED MAINT	6.00
7.00	DENMAN SERVICES	0.00	LAUNDRY SVCS	7.00
8.00	BLESS FOUND	0.00	FUND RAISING	8.00
9.00	BLESS CORP SVCS	0.00	HOME OFFICE	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: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:
2/28/2013 2:41 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	1,370,262	1,225,298	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	240,038	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	1,859,479	1,859,479	3.00
4.00	4.00	EMPLOYEE BENEFITS	12,913	12,913	4.00
5.00	30.00	ADULTS & PEDIATRICS	12,606	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	36,000	0	6.00
7.00	31.00	INTENSIVE CARE UNIT	4,650	4,650	7.00
8.00	41.00	SUBPROVIDER - IRF	36,000	0	8.00
9.00	44.00	SKILLED NURSING FACILITY	1,250	0	9.00
10.00	60.00	LABORATORY	60,000	60,000	10.00
11.00	65.00	RESPIRATORY THERAPY	10,800	0	11.00
12.00	65.00	RESPIRATORY THERAPY	10,800	0	12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	15,000	0	13.00
14.00	69.00	ELECTROCARDIOLOGY	11,700	0	14.00
15.00	69.00	ELECTROCARDIOLOGY	15,900	0	15.00
16.00	70.00	ELECTROENCEPHALOGRAPHY	4,438	0	16.00
17.00	91.00	EMERGENCY	25,350	0	17.00
18.00	91.00	EMERGENCY	84,400	0	18.00
19.00	91.00	EMERGENCY	5,404,151	5,404,151	19.00
20.00	91.00	EMERGENCY	312,570	0	20.00
21.00	91.00	EMERGENCY	149,333	149,333	21.00
22.00	91.00	EMERGENCY	505,078	505,078	22.00
23.00	91.00	EMERGENCY	155,677	155,677	23.00
24.00	50.00	OPERATING ROOM	116,853	0	24.00
25.00	5.00	ADMINISTRATIVE & GENERAL	8,128,259	8,128,259	25.00
26.00	50.00	OPERATING ROOM	189,382	189,382	26.00
27.00	50.00	OPERATING ROOM	618,542	618,542	27.00
28.00	5.00	ADMINISTRATIVE & GENERAL	37,322	37,322	28.00
200.00			19,428,753	18,350,084	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:
2/28/2013 2:41 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	144,964	159,800	1,024	78,671	3,934	1.00
2.00	240,038	208,000	1,488	148,800	7,440	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	12,606	159,800	90	6,914	346	5.00
6.00	36,000	159,800	288	22,126	1,106	6.00
7.00	0	0	0	0	0	7.00
8.00	36,000	159,800	264	20,282	1,014	8.00
9.00	1,250	159,800	10	768	38	9.00
10.00	0	0	0	0	0	10.00
11.00	10,800	159,800	72	5,531	277	11.00
12.00	10,800	159,800	72	5,531	277	12.00
13.00	15,000	159,800	120	9,219	461	13.00
14.00	11,700	159,800	90	6,914	346	14.00
15.00	15,900	182,900	106	9,321	466	15.00
16.00	4,438	159,800	36	2,766	138	16.00
17.00	25,350	159,800	195	14,981	749	17.00
18.00	84,400	159,800	422	32,421	1,621	18.00
19.00	0	0	0	0	0	19.00
20.00	312,570	159,800	1,988	152,732	7,637	20.00
21.00	0	0	0	0	0	21.00
22.00	0	0	0	0	0	22.00
23.00	0	0	0	0	0	23.00
24.00	116,853	182,900	464	40,801	2,040	24.00
25.00	0	0	0	0	0	25.00
26.00	0	0	0	0	0	26.00
27.00	0	0	0	0	0	27.00
28.00	0	0	0	0	0	28.00
200.00	1,078,669		6,729	557,778	27,890	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:
2/28/2013 2:41 pm

	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	
	12.00	13.00	14.00	15.00	16.00	
1.00	0	0	0	0	78,671	1.00
2.00	0	0	0	0	148,800	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	6,914	5.00
6.00	0	0	0	0	22,126	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	20,282	8.00
9.00	0	0	0	0	768	9.00
10.00	0	0	0	0	0	10.00
11.00	0	0	0	0	5,531	11.00
12.00	0	0	0	0	5,531	12.00
13.00	0	0	0	0	9,219	13.00
14.00	0	0	0	0	6,914	14.00
15.00	0	0	0	0	9,321	15.00
16.00	0	0	0	0	2,766	16.00
17.00	0	0	0	0	14,981	17.00
18.00	0	0	0	0	32,421	18.00
19.00	0	0	0	0	0	19.00
20.00	0	0	0	0	152,732	20.00
21.00	0	0	0	0	0	21.00
22.00	0	0	0	0	0	22.00
23.00	0	0	0	0	0	23.00
24.00	0	0	0	0	40,801	24.00
25.00	0	0	0	0	0	25.00
26.00	0	0	0	0	0	26.00
27.00	0	0	0	0	0	27.00
28.00	0	0	0	0	0	28.00
200.00	0	0	0	0	557,778	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:
2/28/2013 2:41 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	66,293	1,291,591	1.00
2.00	91,238	91,238	2.00
3.00	0	1,859,479	3.00
4.00	0	12,913	4.00
5.00	5,692	5,692	5.00
6.00	13,874	13,874	6.00
7.00	0	4,650	7.00
8.00	15,718	15,718	8.00
9.00	482	482	9.00
10.00	0	60,000	10.00
11.00	5,269	5,269	11.00
12.00	5,269	5,269	12.00
13.00	5,781	5,781	13.00
14.00	4,786	4,786	14.00
15.00	6,579	6,579	15.00
16.00	1,672	1,672	16.00
17.00	10,369	10,369	17.00
18.00	51,979	51,979	18.00
19.00	0	5,404,151	19.00
20.00	159,838	159,838	20.00
21.00	0	149,333	21.00
22.00	0	505,078	22.00
23.00	0	155,677	23.00
24.00	76,052	76,052	24.00
25.00	0	8,128,259	25.00
26.00	0	189,382	26.00
27.00	0	618,542	27.00
28.00	0	37,322	28.00
200.00	520,891	18,870,975	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part I
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS				
		BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT	
		1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1.00
1.01 00101	CAP REL COSTS-BUTLER BUILDING	27,904	0	27,904	0	1.01
1.02 00102	CAP REL COSTS-OLD BUILDING & FIXT	279,345	0	0	279,345	1.02
1.03 00103	CAP REL COSTS-NEW BUILDING & FIXT	3,650,490	0	0	0	1.03
1.04 00104	CAP REL COSTS-14TH STREET	796,076	0	0	0	1.04
1.05 00105	CAP REL COSTS-MOB PHASE I	54,967	0	0	0	1.05
2.00 00200	CAP REL COSTS-MVBLE EQUIP	10,137,469	0	0	0	2.00
4.00 00400	EMPLOYEE BENEFITS	23,854,770	0	0	12,546	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	38,074,370	0	0	71,386	5.00
6.00 00600	MAINTENANCE & REPAIRS	5,416,822	0	5,877	36,402	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,012,366	0	0	3,801	8.00
9.00 00900	HOUSEKEEPING	2,225,852	0	0	8,000	9.00
10.00 01000	DIETARY	1,396,045	0	0	0	10.00
11.00 01100	CAFETERIA	2,005,804	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	6,007,630	0	0	6,956	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,490,620	0	0	1,062	16.00
20.00 02000	NURSING SCHOOL	1,525,363	0	22,027	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,033,081	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,514,899	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
23.01 02301	PARAMED ED PRGM-RADIOLOGY	152,364	0	0	0	23.01
23.02 02302	PARAMED ED PRGM-LABORATORY	52,670	0	0	1,103	23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	14,527,796	0	0	14,328	30.00
31.00 03100	INTENSIVE CARE UNIT	3,936,474	0	0	22,405	31.00
40.00 04000	SUBPROVIDER - IPF	3,564,128	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	1,703,266	0	0	1,861	41.00
43.00 04300	NURSERY	447,614	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	1,493,127	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	11,044,591	0	0	22,976	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,325,612	0	0	9,430	52.00
53.00 05300	ANESTHESIOLOGY	462,866	0	0	1,342	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	7,662,130	0	0	0	54.00
60.00 06000	LABORATORY	5,522,327	0	0	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,328,974	0	0	823	62.00
65.00 06500	RESPIRATORY THERAPY	2,126,594	0	0	13,631	65.00
66.00 06600	PHYSICAL THERAPY	1,758,156	0	0	4,537	66.00
67.00 06700	OCCUPATIONAL THERAPY	586,730	0	0	3,509	67.00
68.00 06800	SPEECH PATHOLOGY	277,979	0	0	1,188	68.00
69.00 06900	ELECTROCARDIOLOGY	2,091,150	0	0	12,699	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	326,521	0	0	4,671	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,677,295	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	9,207,245	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	14,982,453	0	0	688	73.00
74.00 07400	RENAL DIALYSIS	740,663	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	748,551	0	0	0	88.00
91.00 09100	EMERGENCY	4,937,733	0	0	15,371	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	3,852,941	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00 11600	HOSPICE	2,146,104	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	205,187,927	0	27,904	270,715	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	5,438	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	2,920,166	0	0	0	192.00
192.01 19201	FASTCARE	515,935	0	0	0	192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
193.01 19301	ADULT DAY CARE	0	0	0	0	193.01
193.02 19302	DENMAN SERVICES	0	0	0	8,157	193.02
193.03 19303	MEALS ON WHEELS	0	0	0	0	193.03
193.04 19304	UNUSED SPACE	0	0	0	2,286	193.04
193.05 19305	HEALTH EDUCATION	15,347	0	0	0	193.05
193.06 19306	RENTED SPACE	0	0	0	906	193.06
193.07 19307	AUGUSTA PHARMACY	942,495	0	0	0	193.07

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS					
		BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT		
200.00	Cross Foot Adjustments	0	1.00	1.01	1.02	1.03	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	209,581,870	0	27,904	279,345	3,650,490	202.00

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	Subtotal	
		14TH STREET	MOB PHASE I	MVBLE EQUIP			
		1.04	1.05	2.00			
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT					1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT					1.03
1.04	00104	CAP REL COSTS-14TH STREET	796,076				1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	0	54,967			1.05
2.00	00200	CAP REL COSTS-MVBLE EQUIP			10,137,469		2.00
4.00	00400	EMPLOYEE BENEFITS	1,388	0	180,012	24,238,678	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	198,613	0	3,237,536	3,369,716	45,624,885
6.00	00600	MAINTENANCE & REPAIRS	181,887	0	155,151	613,079	6,864,102
8.00	00800	LAUNDRY & LINEN SERVICE	1,157	0	5,983	16,784	1,040,091
9.00	00900	HOUSEKEEPING	8,099	0	106,790	537,462	2,889,205
10.00	01000	DIETARY	12,255	0	47,672	167,521	1,715,664
11.00	01100	CAFETERIA	15,759	0	0	383,297	2,432,854
13.00	01300	NURSING ADMINISTRATION	11,735	0	873,532	1,369,924	8,327,486
16.00	01600	MEDICAL RECORDS & LIBRARY	3,488	0	195,453	432,120	3,295,894
20.00	02000	NURSING SCHOOL	21,900	0	88,597	871,264	2,529,151
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	269,320	1,302,401
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	18	0	1,514,917
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	58,758	215,331
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	19,493	73,266
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	264,496	3,546,045	19,027,290
31.00	03100	INTENSIVE CARE UNIT	0	0	189,826	951,173	5,200,630
40.00	04000	SUBPROVIDER - IPF	75,976	0	12,386	906,037	4,558,527
41.00	04100	SUBPROVIDER - IRF	0	0	28,044	383,975	2,162,285
43.00	04300	NURSERY	0	0	8,110	107,732	586,017
44.00	04400	SKILLED NURSING FACILITY	0	0	2,834	362,284	1,926,998
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	39,078	1,494,984	1,796,429	14,607,155
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	34,069	305,726	1,674,837
53.00	05300	ANESTHESIOLOGY	0	0	127,967	47,231	644,936
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,889	1,636,813	1,241,492	10,829,435
60.00	06000	LABORATORY	1,034	0	283,389	787,696	6,693,689
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	48,345	1,378,142
65.00	06500	RESPIRATORY THERAPY	0	0	0	490,456	2,630,681
66.00	06600	PHYSICAL THERAPY	0	0	7,759	410,159	2,223,988
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,990	150,836	744,065
68.00	06800	SPEECH PATHOLOGY	0	0	0	70,667	349,834
69.00	06900	ELECTROCARDIOLOGY	0	0	655,128	358,328	3,154,997
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	16,082	76,046	423,320
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,602	0	28,916	67,270	6,818,651
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,834	0	47,887	111,403	9,441,326
73.00	07300	DRUGS CHARGED TO PATIENTS	1,007	0	224,180	783,547	16,024,127
74.00	07400	RENAL DIALYSIS	0	0	0	0	740,663
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	93,433	841,984
91.00	09100	EMERGENCY	25,216	0	139,207	998,745	6,261,388
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	15,161	0	21,496	736,900	4,626,498
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	22,867	0	9,711	410,067	2,588,749
118.00		SUBTOTALS (SUM OF LINES 1-117)	638,978	54,967	10,127,018	23,350,760	203,985,459
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,669	0	0	0	15,107
192.00	19200	PHYSICIANS' PRIVATE OFFICES	64,410	0	3,589	733,959	3,722,124
192.01	19201	FASTCARE	0	0	6,085	107,805	629,825
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	ADULT DAY CARE	0	0	0	0	0
193.02	19302	DENMAN SERVICES	5,849	0	293	0	14,299
193.03	19303	MEALS ON WHEELS	0	0	0	0	0
193.04	19304	UNUSED SPACE	45,647	0	0	0	49,752
193.05	19305	HEALTH EDUCATION	0	0	0	3,989	19,336
193.06	19306	RENTED SPACE	31,523	0	0	0	160,824
193.07	19307	AUGUSTA PHARMACY	0	0	484	42,165	985,144
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	796,076	54,967	10,137,469	24,238,678	209,581,870

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part I
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	6.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01	
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT					1.02	
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT					1.03	
1.04	00104	CAP REL COSTS-14TH STREET					1.04	
1.05	00105	CAP REL COSTS-MOB PHASE I					1.05	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	45,624,885				5.00	
6.00	00600	MAINTENANCE & REPAIRS	1,910,101	8,774,203			6.00	
8.00	00800	LAUNDRY & LINEN SERVICE	289,430	36,301	1,365,822		8.00	
9.00	00900	HOUSEKEEPING	803,991	113,585	2,074	3,808,855	9.00	
10.00	01000	DIETARY	477,425	257,406	6,293	52,872	2,509,660	10.00
11.00	01100	CAFETERIA	677,000	144,040	0	115,840	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,317,323	118,840	0	55,267	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	917,162	146,634	0	41,082	0	16.00
20.00	02000	NURSING SCHOOL	703,797	718,634	0	108,987	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	362,424	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	421,562	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM--(SPECIFY)	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	59,921	8,692	0	2,248	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	20,388	8,692	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,294,718	1,516,475	590,861	959,695	1,378,985	30.00
31.00	03100	INTENSIVE CARE UNIT	1,447,200	384,685	74,614	276,482	216,894	31.00
40.00	04000	SUBPROVIDER - IPF	1,268,520	415,730	41,702	249,033	472,981	40.00
41.00	04100	SUBPROVIDER - IRF	601,708	107,891	44,207	95,870	206,511	41.00
43.00	04300	NURSERY	163,073	46,593	4,835	25,460	0	43.00
44.00	04400	SKILLED NURSING FACILITY	536,233	141,985	39,543	90,159	234,289	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,064,791	752,711	178,068	457,648	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	466,064	64,010	22,029	100,954	0	52.00
53.00	05300	ANESTHESIOLOGY	179,469	21,999	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,013,550	620,850	110,444	188,313	0	54.00
60.00	06000	LABORATORY	1,862,680	210,611	1,521	70,410	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	383,501	6,485	0	1,105	0	62.00
65.00	06500	RESPIRATORY THERAPY	732,050	107,453	799	75,826	0	65.00
66.00	06600	PHYSICAL THERAPY	618,878	125,342	4,376	64,404	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	207,054	27,659	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	97,350	9,366	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	877,954	177,949	28,843	28,886	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	117,799	36,823	10,229	13,817	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,897,453	146,415	7,157	25,902	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,627,276	242,481	11,851	42,850	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,459,098	77,537	0	33,565	0	73.00
74.00	07400	RENAL DIALYSIS	206,107	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	234,302	0	0	663	0	88.00
91.00	09100	EMERGENCY	1,742,381	558,827	179,238	338,013	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,287,434	82,961	0	135,699	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	720,382	125,123	2,509	23,875	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	44,067,549	7,560,785	1,361,193	3,674,925	2,509,660	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,204	95,780	4,629	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,035,770	352,444	0	0	0	192.00
192.01	19201	FASTCARE	175,264	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT DAY CARE	0	0	0	0	0	193.01
193.02	19302	DENMAN SERVICES	3,979	48,850	0	22,991	0	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	13,845	271,556	0	0	0	193.04
193.05	19305	HEALTH EDUCATION	5,381	0	0	0	0	193.05
193.06	19306	RENTED SPACE	44,753	444,788	0	110,939	0	193.06
193.07	19307	AUGUSTA PHARMACY	274,140	0	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		TOTAL (sum lines 118-201)	45,624,885	8,774,203	1,365,822	3,808,855	2,509,660	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part I
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
		11.00	13.00	16.00	20.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
1.01	00101					1.01
1.02	00102					1.02
1.03	00103					1.03
1.04	00104					1.04
1.05	00105					1.05
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
6.00	00600					6.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100	3,369,734				11.00
13.00	01300	246,272	11,065,188			13.00
16.00	01600	119,911	0	4,520,683		16.00
20.00	02000	146,717	0	0	4,207,286	20.00
21.00	02100	0	0	0	0	21.00
22.00	02200	45,703	0	0	0	22.00
23.00	02300	0	0	0	0	23.00
23.01	02301	9,998	0	0	0	23.01
23.02	02302	2,543	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	687,666	3,883,792	2,461,639	3,080,373	30.00
31.00	03100	158,033	892,530	387,182	255,124	31.00
40.00	04000	176,603	997,433	844,303	232,766	40.00
41.00	04100	70,317	397,122	368,634	31,544	41.00
43.00	04300	16,121	91,035	11,678	56,675	43.00
44.00	04400	74,965	423,404	418,223	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	337,296	1,904,954	0	206,595	50.00
52.00	05200	50,827	287,077	0	165,518	52.00
53.00	05300	12,744	71,965	0	0	53.00
54.00	05400	205,834	0	0	0	54.00
60.00	06000	170,481	0	0	0	60.00
62.00	06200	8,556	0	0	0	62.00
65.00	06500	88,637	0	0	0	65.00
66.00	06600	56,099	0	0	0	66.00
67.00	06700	23,514	0	0	0	67.00
68.00	06800	9,367	0	0	0	68.00
69.00	06900	59,172	0	0	26,691	69.00
70.00	07000	17,111	0	0	0	70.00
71.00	07100	21,666	0	0	0	71.00
72.00	07200	35,884	0	0	0	72.00
73.00	07300	110,817	0	0	0	73.00
74.00	07400	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	0	0	0	0	88.00
91.00	09100	182,437	1,030,384	29,024	135,708	91.00
92.00	09200					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	104,477	590,078	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
116.00	11600	76,049	429,512	0	16,292	116.00
118.00		3,325,817	10,999,286	4,520,683	4,207,286	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
192.00	19200	43,160	0	0	0	192.00
192.01	19201	0	65,902	0	0	192.01
193.00	19300	0	0	0	0	193.00
193.01	19301	0	0	0	0	193.01
193.02	19302	0	0	0	0	193.02
193.03	19303	0	0	0	0	193.03
193.04	19304	0	0	0	0	193.04
193.05	19305	757	0	0	0	193.05
193.06	19306	0	0	0	0	193.06
193.07	19307	0	0	0	0	193.07
200.00						200.00
201.00		0	0	0	0	201.00
202.00		3,369,734	11,065,188	4,520,683	4,207,286	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
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Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
	21.00	22.00	23.00	23.01	23.02	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 CAP REL COSTS-BUTLER BUILDING						1.01
1.02 00102 CAP REL COSTS-OLD BUILDING & FIXT						1.02
1.03 00103 CAP REL COSTS-NEW BUILDING & FIXT						1.03
1.04 00104 CAP REL COSTS-14TH STREET						1.04
1.05 00105 CAP REL COSTS-MOB PHASE I						1.05
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
13.00 01300 NURSING ADMINISTRATION						13.00
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00
20.00 02000 NURSING SCHOOL						20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	1,664,825					21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,982,182				22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
23.01 02301 PARAMED ED PRGM-RADIOLOGY	0	0	0	296,190		23.01
23.02 02302 PARAMED ED PRGM-LABORATORY	0	0	0	0	104,889	23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	1,098,600	1,308,020	0	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	106,475	126,772	0	0	0	31.00
40.00 04000 SUBPROVIDER - IPF	37,664	44,843	0	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	59,753	71,144	0	0	0	41.00
43.00 04300 NURSERY	38,935	46,357	0	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	87,008	103,593	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	3,893	4,636	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	25,983	30,936	0	296,190	0	54.00
60.00 06000 LABORATORY	10,409	12,393	0	0	104,889	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	29,877	35,572	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3,893	4,636	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00 09100 EMERGENCY	162,335	193,280	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,664,825	1,982,182	0	296,190	104,889	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201 FASTCARE	0	0	0	0	0	192.01
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301 ADULT DAY CARE	0	0	0	0	0	193.01
193.02 19302 DENMAN SERVICES	0	0	0	0	0	193.02
193.03 19303 MEALS ON WHEELS	0	0	0	0	0	193.03
193.04 19304 UNUSED SPACE	0	0	0	0	0	193.04
193.05 19305 HEALTH EDUCATION	0	0	0	0	0	193.05
193.06 19306 RENTED SPACE	0	0	0	0	0	193.06
193.07 19307 AUGUSTA PHARMACY	0	0	0	0	0	193.07
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

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Cost Center Description	INTERNS & RESIDENTS					
	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATOR Y	
	21.00	22.00	23.00	23.01	23.02	
202.00 TOTAL (sum lines 118-201)	1,664,825	1,982,182	0	296,190	104,889	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part I
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Steadown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING			1.01
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT			1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT			1.03
1.04	00104	CAP REL COSTS-14TH STREET			1.04
1.05	00105	CAP REL COSTS-MOB PHASE I			1.05
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY			23.01
23.02	02302	PARAMED ED PRGM-LABORATORY			23.02
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	41,288,114	-2,406,620	38,881,494
31.00	03100	INTENSIVE CARE UNIT	9,526,621	-233,247	9,293,374
40.00	04000	SUBPROVIDER - IPF	9,340,105	-82,507	9,257,598
41.00	04100	SUBPROVIDER - IRF	4,216,986	-130,897	4,086,089
43.00	04300	NURSERY	1,086,779	-85,292	1,001,487
44.00	04400	SKILLED NURSING FACILITY	3,885,799	0	3,885,799
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	22,699,819	-190,601	22,509,218
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,831,316	0	2,831,316
53.00	05300	ANESTHESIOLOGY	939,642	-8,529	931,113
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,321,535	-56,919	15,264,616
60.00	06000	LABORATORY	9,137,083	-22,802	9,114,281
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,777,789	0	1,777,789
65.00	06500	RESPIRATORY THERAPY	3,635,446	0	3,635,446
66.00	06600	PHYSICAL THERAPY	3,093,087	0	3,093,087
67.00	06700	OCCUPATIONAL THERAPY	1,002,292	0	1,002,292
68.00	06800	SPEECH PATHOLOGY	465,917	0	465,917
69.00	06900	ELECTROCARDIOLOGY	4,419,941	-65,449	4,354,492
70.00	07000	ELECTROENCEPHALOGRAPHY	619,099	0	619,099
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,917,244	0	8,917,244
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,401,668	0	12,401,668
73.00	07300	DRUGS CHARGED TO PATIENTS	20,713,673	-8,529	20,705,144
74.00	07400	RENAL DIALYSIS	946,770	0	946,770
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,076,949	0	1,076,949
91.00	09100	EMERGENCY	10,813,015	-355,615	10,457,400
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	6,827,147	0	6,827,147
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			
116.00	11600	HOSPICE	3,982,491	0	3,982,491
118.00		SUBTOTALS (SUM OF LINES 1-117)	200,966,327	-3,647,007	197,319,320
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	119,720	0	119,720
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,153,498	0	5,153,498
192.01	19201	FASTCARE	870,991	0	870,991
193.00	19300	NONPAID WORKERS	0	0	0
193.01	19301	ADULT DAY CARE	0	0	0
193.02	19302	DENMAN SERVICES	90,119	0	90,119
193.03	19303	MEALS ON WHEELS	0	0	0
193.04	19304	UNUSED SPACE	335,153	0	335,153
193.05	19305	HEALTH EDUCATION	25,474	0	25,474
193.06	19306	RENTED SPACE	761,304	0	761,304
193.07	19307	AUGUSTA PHARMACY	1,259,284	0	1,259,284
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
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To 09/30/2012

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Part I
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Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24,00	25,00	26,00	
202.00 TOTAL (sum lines 118-201)	209,581,870	-3,647,007	205,934,863	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part II
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
		BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT	
		0	1.00	1.01	1.02	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02 00102	CAP REL COSTS-OLD BUILDING & FIXT					1.02
1.03 00103	CAP REL COSTS-NEW BUILDING & FIXT					1.03
1.04 00104	CAP REL COSTS-14TH STREET					1.04
1.05 00105	CAP REL COSTS-MOB PHASE I					1.05
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	0	12,546	189,962 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	9,499	0	0	71,386	673,264 5.00
6.00 00600	MAINTENANCE & REPAIRS	789	0	5,877	36,402	454,884 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	3,801	0 8.00
9.00 00900	HOUSEKEEPING	0	0	0	8,000	3,002 9.00
10.00 01000	DIETARY	713	0	0	0	92,171 10.00
11.00 01100	CAFETERIA	0	0	0	0	27,994 11.00
13.00 01300	NURSING ADMINISTRATION	4,684	0	0	6,956	57,709 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,062	173,151 16.00
20.00 02000	NURSING SCHOOL	0	0	22,027	0	0 20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0 22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
23.01 02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	4,209 23.01
23.02 02302	PARAMED ED PRGM-LABORATORY	0	0	0	1,103	0 23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	76,810	0	0	14,328	674,625 30.00
31.00 03100	INTENSIVE CARE UNIT	34,754	0	0	22,405	100,752 31.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	0 40.00
41.00 04100	SUBPROVIDER - IRF	2,816	0	0	1,861	45,139 41.00
43.00 04300	NURSERY	0	0	0	0	22,561 43.00
44.00 04400	SKILLED NURSING FACILITY	20,531	0	0	0	68,753 44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	831,462	0	0	22,976	209,097 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	9,430	0 52.00
53.00 05300	ANESTHESIOLOGY	13,416	0	0	1,342	5,530 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	953,406	0	0	0	273,111 54.00
60.00 06000	LABORATORY	75,934	0	0	0	99,243 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	823	0 62.00
65.00 06500	RESPIRATORY THERAPY	78,439	0	0	13,631	0 65.00
66.00 06600	PHYSICAL THERAPY	47,835	0	0	4,537	43,377 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	3,509	0 67.00
68.00 06800	SPEECH PATHOLOGY	2,490	0	0	1,188	0 68.00
69.00 06900	ELECTROCARDIOLOGY	167,536	0	0	12,699	37,692 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	31,312	0	0	4,671	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	122,251	0	0	0	29,568 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	48,957 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	688	32,252 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	32,433	0	0	0	0 88.00
91.00 09100	EMERGENCY	82	0	0	15,371	145,116 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	1,957	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	108,704	0	0	0	0 116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	2,617,853	0	27,904	270,715	3,512,119 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	5,438	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	11,004	0	0	0	0 192.00
192.01 19201	FASTCARE	67,553	0	0	0	0 192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
193.01 19301	ADULT DAY CARE	0	0	0	0	0 193.01
193.02 19302	DENMAN SERVICES	0	0	0	0	8,157 193.02
193.03 19303	MEALS ON WHEELS	0	0	0	0	0 193.03
193.04 19304	UNUSED SPACE	0	0	0	2,286	1,819 193.04
193.05 19305	HEALTH EDUCATION	0	0	0	0	0 193.05
193.06 19306	RENTED SPACE	0	0	0	906	128,395 193.06
193.07 19307	AUGUSTA PHARMACY	0	0	0	0	0 193.07
200.00 20000	Cross Foot Adjustments					

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT	
		0	1.00	1.01	1.02	1.03	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,696,410	0	27,904	279,345	3,650,490	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

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Part II
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Cost Center Description		CAPITAL RELATED COSTS			Subtotal	EMPLOYEE BENEFITS	
		14TH STREET	MOB PHASE I	MVBLE EQUIP			
		1.04	1.05	2.00			
					2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT					1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT					1.03
1.04	00104	CAP REL COSTS-14TH STREET					1.04
1.05	00105	CAP REL COSTS-MOB PHASE I					1.05
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS	1,388	0	180,012	383,908	383,908 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	198,613	0	3,237,536	4,190,298	53,371 5.00
6.00	00600	MAINTENANCE & REPAIRS	181,887	0	155,151	834,990	9,710 6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,157	0	5,983	10,941	266 8.00
9.00	00900	HOUSEKEEPING	8,099	0	106,790	125,891	8,513 9.00
10.00	01000	DIETARY	12,255	0	47,672	152,811	2,653 10.00
11.00	01100	CAFETERIA	15,759	0	0	43,753	6,071 11.00
13.00	01300	NURSING ADMINISTRATION	11,735	0	873,532	954,616	21,697 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,488	0	195,453	373,154	6,844 16.00
20.00	02000	NURSING SCHOOL	21,900	0	88,597	132,524	13,799 20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	4,266 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	18	18	0 22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	4,209	931 23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	1,103	309 23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	264,496	1,030,259	56,172 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	189,826	347,737	15,065 31.00
40.00	04000	SUBPROVIDER - IPF	75,976	0	12,386	88,362	14,350 40.00
41.00	04100	SUBPROVIDER - IRF	0	0	28,044	77,860	6,082 41.00
43.00	04300	NURSERY	0	0	8,110	30,671	1,706 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	2,834	92,118	5,738 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	39,078	1,494,984	2,597,597	28,453 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	34,069	43,499	4,842 52.00
53.00	05300	ANESTHESIOLOGY	0	0	127,967	148,255	748 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,889	1,636,813	2,879,219	19,663 54.00
60.00	06000	LABORATORY	1,034	0	283,389	459,600	12,476 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	823	766 62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	92,070	7,768 65.00
66.00	06600	PHYSICAL THERAPY	0	0	7,759	103,508	6,496 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,990	6,499	2,389 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,678	1,119 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	655,128	873,055	5,675 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	16,082	52,065	1,204 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,602	0	28,916	196,337	1,065 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,834	0	47,887	122,678	1,764 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,007	0	224,180	258,127	12,410 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	32,433	1,480 88.00
91.00	09100	EMERGENCY	25,216	0	139,207	324,992	15,818 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	15,161	0	21,496	38,614	11,671 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0 113.00
116.00	11600	HOSPICE	22,867	0	9,711	141,282	6,495 116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	638,978	54,967	10,127,018	17,249,554	369,845 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,669	0	0	15,107	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	64,410	0	3,589	79,003	11,625 192.00
192.01	19201	FASTCARE	0	0	6,085	73,638	1,707 192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0 193.00
193.01	19301	ADULT DAY CARE	0	0	0	0	0 193.01
193.02	19302	DENMAN SERVICES	5,849	0	293	14,299	0 193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0 193.03
193.04	19304	UNUSED SPACE	45,647	0	0	49,752	0 193.04
193.05	19305	HEALTH EDUCATION	0	0	0	0	63 193.05
193.06	19306	RENTED SPACE	31,523	0	0	160,824	0 193.06
193.07	19307	AUGUSTA PHARMACY	0	0	484	484	668 193.07
200.00		Cross Foot Adjustments	0	0	0	0	0 200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	796,076	54,967	10,137,469	17,642,661	383,908 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00104						1.04
1.05	00105						1.05
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	4,243,669					5.00
6.00	00600	177,664	1,022,364				6.00
8.00	00800	26,921	4,230	42,358			8.00
9.00	00900	74,781	13,235	64	222,484		9.00
10.00	01000	44,407	29,993	195	3,088	233,147	10.00
11.00	01100	62,970	16,783	0	6,766	0	11.00
13.00	01300	215,540	13,847	0	3,228	0	13.00
16.00	01600	85,308	17,086	0	2,400	0	16.00
20.00	02000	65,462	83,735	0	6,366	0	20.00
21.00	02100	33,710	0	0	0	0	21.00
22.00	02200	39,211	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
23.01	02301	5,573	1,013	0	131	0	23.01
23.02	02302	1,896	1,013	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	492,452	176,699	18,325	56,059	128,108	30.00
31.00	03100	134,608	44,823	2,314	16,150	20,149	31.00
40.00	04000	117,988	48,441	1,293	14,547	43,940	40.00
41.00	04100	55,966	12,571	1,371	5,600	19,185	41.00
43.00	04300	15,168	5,429	150	1,487	0	43.00
44.00	04400	49,876	16,544	1,226	5,266	21,765	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	378,077	87,705	5,522	26,732	0	50.00
52.00	05200	43,350	7,458	683	5,897	0	52.00
53.00	05300	16,693	2,563	0	0	0	53.00
54.00	05400	280,298	72,341	3,425	11,000	0	54.00
60.00	06000	173,253	24,540	47	4,113	0	60.00
62.00	06200	35,670	756	0	65	0	62.00
65.00	06500	68,090	12,520	25	4,429	0	65.00
66.00	06600	57,563	14,605	136	3,762	0	66.00
67.00	06700	19,259	3,223	0	0	0	67.00
68.00	06800	9,055	1,091	0	0	0	68.00
69.00	06900	81,661	20,734	894	1,687	0	69.00
70.00	07000	10,957	4,291	317	807	0	70.00
71.00	07100	176,487	17,060	222	1,513	0	71.00
72.00	07200	244,370	28,254	368	2,503	0	72.00
73.00	07300	414,752	9,035	0	1,961	0	73.00
74.00	07400	19,171	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	21,793	0	0	39	0	88.00
91.00	09100	162,064	65,114	5,559	19,744	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	119,748	9,667	0	7,926	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	67,005	14,579	78	1,395	0	116.00
118.00		4,098,817	880,978	42,214	214,661	233,147	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	391	11,160	144	0	0	190.00
192.00	19200	96,340	41,067	0	0	0	192.00
192.01	19201	16,302	0	0	0	0	192.01
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	370	5,692	0	1,343	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	1,288	31,641	0	0	0	193.04
193.05	19305	500	0	0	0	0	193.05
193.06	19306	4,163	51,826	0	6,480	0	193.06
193.07	19307	25,498	0	0	0	0	193.07
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		4,243,669	1,022,364	42,358	222,484	233,147	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

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Part II
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
		11.00	13.00	16.00	20.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
1.01	00101					1.01
1.02	00102					1.02
1.03	00103					1.03
1.04	00104					1.04
1.05	00105					1.05
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
6.00	00600					6.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	136,343	9,964			13.00
16.00	01600		1,218,892	489,644		16.00
20.00	02000	5,936	0	0	307,822	20.00
21.00	02100	0	0	0	0	21.00
22.00	02200	1,849	0	0	0	22.00
23.00	02300	0	0	0	0	23.00
23.01	02301	405	0	0	0	23.01
23.02	02302	103	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	27,824	427,823	266,625		30.00
31.00	03100	6,394	98,317	41,936		31.00
40.00	04000	7,146	109,873	91,448		40.00
41.00	04100	2,845	43,745	39,927		41.00
43.00	04300	652	10,028	1,265		43.00
44.00	04400	3,033	46,640	45,299		44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	13,647	209,841	0		50.00
52.00	05200	2,057	31,623	0		52.00
53.00	05300	516	7,927	0		53.00
54.00	05400	8,328	0	0		54.00
60.00	06000	6,898	0	0		60.00
62.00	06200	346	0	0		62.00
65.00	06500	3,586	0	0		65.00
66.00	06600	2,270	0	0		66.00
67.00	06700	951	0	0		67.00
68.00	06800	379	0	0		68.00
69.00	06900	2,394	0	0		69.00
70.00	07000	692	0	0		70.00
71.00	07100	877	0	0		71.00
72.00	07200	1,452	0	0		72.00
73.00	07300	4,484	0	0		73.00
74.00	07400	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	0	0	0		88.00
91.00	09100	7,382	113,503	3,144		91.00
92.00	09200					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	4,227	65,000	0		101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
116.00	11600	3,077	47,313	0		116.00
118.00		134,566	1,211,633	489,644	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0		190.00
192.00	19200	1,746	0	0		192.00
192.01	19201	0	7,259	0		192.01
193.00	19300	0	0	0		193.00
193.01	19301	0	0	0		193.01
193.02	19302	0	0	0		193.02
193.03	19303	0	0	0		193.03
193.04	19304	0	0	0		193.04
193.05	19305	31	0	0		193.05
193.06	19306	0	0	0		193.06
193.07	19307	0	0	0		193.07
200.00					307,822	200.00
201.00		0	0	0	0	201.00
202.00		136,343	1,218,892	489,644	307,822	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part II
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Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
	21.00	22.00				
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING				1.01
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT				1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT				1.03
1.04	00104	CAP REL COSTS-14TH STREET				1.04
1.05	00105	CAP REL COSTS-MOB PHASE I				1.05
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
20.00	02000	NURSING SCHOOL				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	37,976			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		41,078		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY			12,262	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY				4,424
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM				50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				52.00
53.00	05300	ANESTHESIOLOGY				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				54.00
60.00	06000	LABORATORY				60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS				62.00
65.00	06500	RESPIRATORY THERAPY				65.00
66.00	06600	PHYSICAL THERAPY				66.00
67.00	06700	OCCUPATIONAL THERAPY				67.00
68.00	06800	SPEECH PATHOLOGY				68.00
69.00	06900	ELECTROCARDIOLOGY				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				73.00
74.00	07400	RENAL DIALYSIS				74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				192.00
192.01	19201	FASTCARE				192.01
193.00	19300	NONPAID WORKERS				193.00
193.01	19301	ADULT DAY CARE				193.01
193.02	19302	DENMAN SERVICES				193.02
193.03	19303	MEALS ON WHEELS				193.03
193.04	19304	UNUSED SPACE				193.04
193.05	19305	HEALTH EDUCATION				193.05
193.06	19306	RENTED SPACE				193.06
193.07	19307	AUGUSTA PHARMACY				193.07
200.00		Cross Foot Adjustments	37,976	41,078	0	12,262
201.00		Negative Cost Centers	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part II
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description	INTERNS & RESIDENTS					
	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATOR Y	
	21.00	22.00	23.00	23.01	23.02	
202.00 TOTAL (sum lines 118-201)	37,976	41,078	0	12,262	4,424	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part II
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24,00	25,00	26,00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
1.01	00101				1.01
1.02	00102				1.02
1.03	00103				1.03
1.04	00104				1.04
1.05	00105				1.05
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
16.00	01600				16.00
20.00	02000				20.00
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
23.01	02301				23.01
23.02	02302				23.02
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	2,680,346	0	2,680,346	30.00
31.00	03100	727,493	0	727,493	31.00
40.00	04000	537,388	0	537,388	40.00
41.00	04100	265,152	0	265,152	41.00
43.00	04300	66,556	0	66,556	43.00
44.00	04400	287,505	0	287,505	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	3,347,574	0	3,347,574	50.00
52.00	05200	139,409	0	139,409	52.00
53.00	05300	176,702	0	176,702	53.00
54.00	05400	3,274,274	0	3,274,274	54.00
60.00	06000	680,927	0	680,927	60.00
62.00	06200	38,426	0	38,426	62.00
65.00	06500	188,488	0	188,488	65.00
66.00	06600	188,340	0	188,340	66.00
67.00	06700	32,321	0	32,321	67.00
68.00	06800	15,322	0	15,322	68.00
69.00	06900	986,100	0	986,100	69.00
70.00	07000	70,333	0	70,333	70.00
71.00	07100	393,561	0	393,561	71.00
72.00	07200	401,389	0	401,389	72.00
73.00	07300	700,769	0	700,769	73.00
74.00	07400	19,171	0	19,171	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	55,745	0	55,745	88.00
91.00	09100	717,320	0	717,320	91.00
92.00	09200		0		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	256,853	0	256,853	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
116.00	11600	281,224	0	281,224	116.00
118.00		16,528,688	0	16,528,688	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	26,802	0	26,802	190.00
192.00	19200	229,781	0	229,781	192.00
192.01	19201	98,906	0	98,906	192.01
193.00	19300	0	0	0	193.00
193.01	19301	0	0	0	193.01
193.02	19302	21,704	0	21,704	193.02
193.03	19303	0	0	0	193.03
193.04	19304	82,681	0	82,681	193.04
193.05	19305	594	0	594	193.05
193.06	19306	223,293	0	223,293	193.06
193.07	19307	26,650	0	26,650	193.07
200.00		403,562	0	403,562	200.00
201.00		0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part II
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
202.00 TOTAL (sum lines 118-201)	17,642,661	0	17,642,661	202.00

Cost Center Description		CAPITAL RELATED COSTS					14TH STREET (SQ. FEET)	
		BLDG & FIXT (SQ. FEET)	BUTLER BUILDING (SQ. FEET)	OLD BUILDING & FIXT (SQ. FEET)	NEW BUILDING & FIXT (SQ. FEET)			
		1.00	1.01	1.02	1.03	1.04		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	0					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING		18,141				1.01
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT	0	0	130,726			1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT	0	0	0	447,544		1.03
1.04	00104	CAP REL COSTS-14TH STREET	0	0	0	0	258,596	1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	0	0	0	0	0	1.05
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	5,871	23,289	451	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	0	33,407	82,541	64,516	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	3,821	17,035	55,768	59,084	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,779	0	376	8.00
9.00	00900	HOUSEKEEPING	0	0	3,744	368	2,631	9.00
10.00	01000	DIETARY	0	0	0	11,300	3,981	10.00
11.00	01100	CAFETERIA	0	0	0	3,432	5,119	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	3,255	7,075	3,812	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	497	21,228	1,133	16.00
20.00	02000	NURSING SCHOOL	0	14,320	0	0	7,114	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	516	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	516	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	6,705	82,708	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	10,485	12,352	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	24,680	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	871	5,534	0	41.00
43.00	04300	NURSERY	0	0	0	2,766	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	8,429	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	10,752	25,635	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	4,413	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	628	678	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	33,483	0	54.00
60.00	06000	LABORATORY	0	0	0	12,167	336	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	385	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	6,379	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,123	5,318	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,642	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	556	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	5,943	4,621	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	2,186	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,625	5,068	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,002	8,392	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	322	3,954	327	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	7,193	17,791	8,191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	4,925	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	7,428	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	18,141	126,687	430,580	207,564	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,545	0	3,141	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	20,923	192.00
192.01	19201	FASTCARE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT DAY CARE	0	0	0	0	0	193.01
193.02	19302	DENMAN SERVICES	0	0	0	1,000	1,900	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	1,070	223	14,828	193.04
193.05	19305	HEALTH EDUCATION	0	0	0	0	0	193.05
193.06	19306	RENTED SPACE	0	0	424	15,741	10,240	193.06
193.07	19307	AUGUSTA PHARMACY	0	0	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet B-1

Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		CAPITAL RELATED COSTS					14TH STREET (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BUILDING & FIXT (SQUARE FEET)	NEW BUILDING & FIXT (SQUARE FEET)			
		1.00	1.01	1.02	1.03	1.04		
202.00	Cost to be allocated (per wkst. B, Part I)	0	27,904	279,345	3,650,490	796,076	202.00	
203.00	Unit cost multiplier (wkst. B, Part I)	0.000000	1.538173	2.136874	8.156718	3.078454	203.00	
204.00	Cost to be allocated (per wkst. B, Part II)						204.00	
205.00	Unit cost multiplier (wkst. B, Part II)						205.00	

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	MOB PHASE I (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.05	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02 00102	CAP REL COSTS-OLD BUILDING & FIXT					1.02
1.03 00103	CAP REL COSTS-NEW BUILDING & FIXT					1.03
1.04 00104	CAP REL COSTS-14TH STREET					1.04
1.05 00105	CAP REL COSTS-MOB PHASE I	11,672				1.05
2.00 00200	CAP REL COSTS-MVBLE EQUIP		9,929,233			2.00
4.00 00400	EMPLOYEE BENEFITS	0	176,314	92,976,883		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	3,171,032	12,925,843	-45,624,885	163,956,985
6.00 00600	MAINTENANCE & REPAIRS	0	151,964	2,351,700	0	6,864,102
8.00 00800	LAUNDRY & LINEN SERVICE	0	5,860	64,383	0	1,040,091
9.00 00900	HOUSEKEEPING	0	104,596	2,061,643	0	2,889,205
10.00 01000	DIETARY	0	46,693	642,591	0	1,715,664
11.00 01100	CAFETERIA	0	0	1,470,285	0	2,432,854
13.00 01300	NURSING ADMINISTRATION	0	855,589	5,254,872	0	8,327,486
16.00 01600	MEDICAL RECORDS & LIBRARY	0	191,438	1,657,562	0	3,295,894
20.00 02000	NURSING SCHOOL	0	86,777	3,342,068	0	2,529,151
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,033,081	0	1,302,401
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	18	0	0	1,514,917
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
23.01 02301	PARAMED ED PRGM-RADIOLOGY	0	0	225,390	0	215,331
23.02 02302	PARAMED ED PRGM-LABORATORY	0	0	74,774	0	73,266
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	259,063	13,602,310	0	19,027,290
31.00 03100	INTENSIVE CARE UNIT	0	185,927	3,648,591	0	5,200,630
40.00 04000	SUBPROVIDER - IPF	0	12,132	3,475,456	0	4,558,527
41.00 04100	SUBPROVIDER - IRF	0	27,468	1,472,884	0	2,162,285
43.00 04300	NURSERY	0	7,943	413,246	0	586,017
44.00 04400	SKILLED NURSING FACILITY	0	2,776	1,389,680	0	1,926,998
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	8,298	1,464,275	6,890,894	0	14,607,155
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	33,369	1,172,731	0	1,674,837
53.00 05300	ANESTHESIOLOGY	0	125,338	181,172	0	644,936
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,374	1,603,191	4,762,220	0	10,829,435
60.00 06000	LABORATORY	0	277,568	3,021,510	0	6,693,689
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	185,447	0	1,378,142
65.00 06500	RESPIRATORY THERAPY	0	0	1,881,334	0	2,630,681
66.00 06600	PHYSICAL THERAPY	0	7,600	1,573,324	0	2,223,988
67.00 06700	OCCUPATIONAL THERAPY	0	2,929	578,588	0	744,065
68.00 06800	SPEECH PATHOLOGY	0	0	271,070	0	349,834
69.00 06900	ELECTROCARDIOLOGY	0	641,671	1,374,507	0	3,154,997
70.00 07000	ELECTROENCEPHALOGRAPHY	0	15,752	291,702	0	423,320
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	28,322	258,041	0	6,818,651
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	46,903	427,328	0	9,441,326
73.00 07300	DRUGS CHARGED TO PATIENTS	0	219,575	3,005,595	0	16,024,127
74.00 07400	RENAL DIALYSIS	0	0	0	0	740,663
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	358,399	0	841,984
91.00 09100	EMERGENCY	0	136,348	3,831,072	0	6,261,388
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	21,054	2,826,665	0	4,626,498
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
116.00 11600	HOSPICE	0	9,512	1,572,971	0	2,588,749
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,672	9,918,997	89,570,929	-45,624,885	158,360,574
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	15,107
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	3,515	2,815,384	0	3,722,124
192.01 19201	FASTCARE	0	5,960	413,528	0	629,825
193.00 19300	NONPAID WORKERS	0	0	0	0	0
193.01 19301	ADULT DAY CARE	0	0	0	0	0
193.02 19302	DENMAN SERVICES	0	287	0	0	14,299
193.03 19303	MEALS ON WHEELS	0	0	0	0	0
193.04 19304	UNUSED SPACE	0	0	0	0	49,752
193.05 19305	HEALTH EDUCATION	0	0	15,301	0	19,336
193.06 19306	RENTED SPACE	0	0	0	0	160,824
193.07 19307	AUGUSTA PHARMACY	0	474	161,741	0	985,144
200.00	Cross Foot Adjustments					200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet B-1

Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	MOB PHASE I (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.05	2.00				
201.00 Negative Cost Centers			4.00	5A	5.00	201.00
202.00 Cost to be allocated (per wkst. B, Part I)	54,967	10,137,469	24,238,678		45,624,885	202.00
203.00 Unit cost multiplier (wkst. B, Part I)	4.709304	1.020972	0.260696		0.278274	203.00
204.00 Cost to be allocated (per wkst. B, Part II)			383,908		4,243,669	204.00
205.00 Unit cost multiplier (wkst. B, Part II)			0.004129		0.025883	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet B-1

Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		6.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00104						1.04
1.05	00105						1.05
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	520,884					6.00
8.00	00800	2,155	1,524,426				8.00
9.00	00900	6,743	2,315	103,376			9.00
10.00	01000	15,281	7,024	1,435	197,226		10.00
11.00	01100	8,551	0	3,144	0	432,067	11.00
13.00	01300	7,055	0	1,500	0	31,577	13.00
16.00	01600	8,705	0	1,115	0	15,375	16.00
20.00	02000	42,662	0	2,958	0	18,812	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	5,860	22.00
23.00	02300	0	0	0	0	0	23.00
23.01	02301	516	0	61	0	1,282	23.01
23.02	02302	516	0	0	0	326	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	90,026	659,473	26,047	108,370	88,173	30.00
31.00	03100	22,837	83,279	7,504	17,045	20,263	31.00
40.00	04000	24,680	46,545	6,759	37,170	22,644	40.00
41.00	04100	6,405	49,340	2,602	16,229	9,016	41.00
43.00	04300	2,766	5,397	691	0	2,067	43.00
44.00	04400	8,429	44,135	2,447	18,412	9,612	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	44,685	198,746	12,421	0	43,248	50.00
52.00	05200	3,800	24,587	2,740	0	6,517	52.00
53.00	05300	1,306	0	0	0	1,634	53.00
54.00	05400	36,857	123,269	5,111	0	26,392	54.00
60.00	06000	12,503	1,698	1,911	0	21,859	60.00
62.00	06200	385	0	30	0	1,097	62.00
65.00	06500	6,379	892	2,058	0	11,365	65.00
66.00	06600	7,441	4,884	1,748	0	7,193	66.00
67.00	06700	1,642	0	0	0	3,015	67.00
68.00	06800	556	0	0	0	1,201	68.00
69.00	06900	10,564	32,192	784	0	7,587	69.00
70.00	07000	2,186	11,417	375	0	2,194	70.00
71.00	07100	8,692	7,988	703	0	2,778	71.00
72.00	07200	14,395	13,227	1,163	0	4,601	72.00
73.00	07300	4,603	0	911	0	14,209	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	18	0	0	88.00
91.00	09100	33,175	200,052	9,174	0	23,392	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	4,925	0	3,683	0	13,396	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	7,428	2,800	648	0	9,751	116.00
118.00		448,849	1,519,260	99,741	197,226	426,436	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	5,686	5,166	0	0	0	190.00
192.00	19200	20,923	0	0	0	5,534	192.00
192.01	19201	0	0	0	0	0	192.01
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	2,900	0	624	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	16,121	0	0	0	0	193.04
193.05	19305	0	0	0	0	97	193.05
193.06	19306	26,405	0	3,011	0	0	193.06
193.07	19307	0	0	0	0	0	193.07
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet B-1
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		6.00	8.00	9.00	10.00	11.00	
202.00	Cost to be allocated (per wkst. B, Part I)	8,774,203	1,365,822	3,808,855	2,509,660	3,369,734	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	16.844831	0.895958	36.844674	12.724793	7.799101	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	1,022,364	42,358	222,484	233,147	136,343	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	1.962748	0.027786	2.152182	1.182131	0.315560	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet B-1

Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		
				SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	
				13.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02 00102	CAP REL COSTS-OLD BUILDING & FIXT					1.02
1.03 00103	CAP REL COSTS-NEW BUILDING & FIXT					1.03
1.04 00104	CAP REL COSTS-14TH STREET					1.04
1.05 00105	CAP REL COSTS-MOB PHASE I					1.05
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION	1,695,489				13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	105,293			16.00
20.00 02000	NURSING SCHOOL	0	0	24,275		20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	20,952	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
23.01 02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	23.01
23.02 02302	PARAMED ED PRGM-LABORATORY	0	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	595,103	57,335	17,773	13,826	13,826
31.00 03100	INTENSIVE CARE UNIT	136,760	9,018	1,472	1,340	1,340
40.00 04000	SUBPROVIDER - IPF	152,834	19,665	1,343	474	474
41.00 04100	SUBPROVIDER - IRF	60,850	8,586	182	752	752
43.00 04300	NURSERY	13,949	272	327	490	490
44.00 04400	SKILLED NURSING FACILITY	64,877	9,741	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	291,891	0	1,192	1,095	1,095
52.00 05200	DELIVERY ROOM & LABOR ROOM	43,988	0	955	0	0
53.00 05300	ANESTHESIOLOGY	11,027	0	0	49	49
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	327	327
60.00 06000	LABORATORY	0	0	0	131	131
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00 06600	PHYSICAL THERAPY	0	0	0	0	0
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00 06900	ELECTROCARDIOLOGY	0	0	154	376	376
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	49	49
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	157,883	676	783	2,043	2,043
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	90,416	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
116.00 11600	HOSPICE	65,813	0	94	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,685,391	105,293	24,275	20,952	20,952
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01 19201	FASTCARE	10,098	0	0	0	0
193.00 19300	NONPAID WORKERS	0	0	0	0	0
193.01 19301	ADULT DAY CARE	0	0	0	0	0
193.02 19302	DENMAN SERVICES	0	0	0	0	0
193.03 19303	MEALS ON WHEELS	0	0	0	0	0
193.04 19304	UNUSED SPACE	0	0	0	0	0
193.05 19305	HEALTH EDUCATION	0	0	0	0	0
193.06 19306	RENTED SPACE	0	0	0	0	0
193.07 19307	AUGUSTA PHARMACY	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet B-1

Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		
					SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	
200.00	Cross Foot Adjustments	13.00	16.00	20.00	21.00	22.00	200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	11,065,188	4,520,683	4,207,286	1,664,825	1,982,182	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6.526252	42.934317	173.317652	79.459002	94.605861	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,218,892	489,644	307,822	37,976	41,078	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.718903	4.650300	12.680618	1.812524	1.960577	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet B-1

Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)	
		23.00	23.01	23.02	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING			1.01
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT			1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT			1.03
1.04	00104	CAP REL COSTS-14TH STREET			1.04
1.05	00105	CAP REL COSTS-MOB PHASE I			1.05
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	T&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	T&R SERVICES-OTHER PRGM COSTS APPRVD			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	100	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	100
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	0
31.00	03100	INTENSIVE CARE UNIT	0	0	0
40.00	04000	SUBPROVIDER - IPF	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0
43.00	04300	NURSERY	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	100	0
60.00	06000	LABORATORY	0	0	100
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0
66.00	06600	PHYSICAL THERAPY	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0
91.00	09100	EMERGENCY	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	100	100
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0
192.01	19201	FASTCARE	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0
193.01	19301	ADULT DAY CARE	0	0	0
193.02	19302	DENMAN SERVICES	0	0	0
193.03	19303	MEALS ON WHEELS	0	0	0
193.04	19304	UNUSED SPACE	0	0	0
193.05	19305	HEALTH EDUCATION	0	0	0
193.06	19306	RENTED SPACE	0	0	0
193.07	19307	AUGUSTA PHARMACY	0	0	0
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet B-1

Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATOR Y (ASSIGNED TIME)	
		23.00	23.01	23.02	
202.00	Cost to be allocated (per wkst. B, Part I)	0	296,190	104,889	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	0.000000	2,961.900000	1,048.890000	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	0	12,262	4,424	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.000000	122.620000	44.240000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet C
Part I
Date/Time Prepared:
2/28/2013 2:41 pm

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		Total Costs
				RCE Disallowance		
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		38,881,494		5,692	38,887,186 30.00
31.00	03100 INTENSIVE CARE UNIT		9,293,374		13,874	9,307,248 31.00
40.00	04000 SUBPROVIDER - IPF		9,257,598		0	9,257,598 40.00
41.00	04100 SUBPROVIDER - IRF		4,086,089		15,718	4,101,807 41.00
43.00	04300 NURSERY		1,001,487		0	1,001,487 43.00
44.00	04400 SKILLED NURSING FACILITY		3,885,799		482	3,886,281 44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		22,509,218		76,052	22,585,270 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		2,831,316		0	2,831,316 52.00
53.00	05300 ANESTHESIOLOGY		931,113		0	931,113 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		15,264,616		0	15,264,616 54.00
60.00	06000 LABORATORY		9,114,281		0	9,114,281 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		1,777,789		0	1,777,789 62.00
65.00	06500 RESPIRATORY THERAPY	0	3,635,446		10,538	3,645,984 65.00
66.00	06600 PHYSICAL THERAPY	0	3,093,087		0	3,093,087 66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,002,292		0	1,002,292 67.00
68.00	06800 SPEECH PATHOLOGY	0	465,917		0	465,917 68.00
69.00	06900 ELECTROCARDIOLOGY		4,354,492		11,365	4,365,857 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		619,099		7,453	626,552 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		8,917,244		0	8,917,244 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		12,401,668		0	12,401,668 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		20,705,144		0	20,705,144 73.00
74.00	07400 RENAL DIALYSIS		946,770		0	946,770 74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		1,076,949		0	1,076,949 88.00
91.00	09100 EMERGENCY		10,457,400		222,186	10,679,586 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		7,543,009		0	7,543,009 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY		6,827,147		0	6,827,147 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
116.00	11600 HOSPICE		3,982,491			3,982,491 116.00
200.00	Subtotal (see instructions)	0	204,862,329		363,360	205,225,689 200.00
201.00	Less Observation Beds		7,543,009			7,543,009 201.00
202.00	Total (see instructions)	0	197,319,320		363,360	197,682,680 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet C
Part I
Date/Time Prepared:
2/28/2013 2:41 pm

		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
				9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	55,604,365		55,604,365		30.00
31.00	03100	INTENSIVE CARE UNIT	28,929,735		28,929,735		31.00
40.00	04000	SUBPROVIDER - IPF	20,149,452		20,149,452		40.00
41.00	04100	SUBPROVIDER - IRF	4,875,727		4,875,727		41.00
43.00	04300	NURSERY	2,707,980		2,707,980		43.00
44.00	04400	SKILLED NURSING FACILITY	4,400,105		4,400,105		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	21,727,096	43,357,743	65,084,839	0.345844	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,667,958	450,719	4,118,677	0.687433	52.00
53.00	05300	ANESTHESIOLOGY	5,696,320	7,791,074	13,487,394	0.069036	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,089,450	82,894,595	100,984,045	0.151159	54.00
60.00	06000	LABORATORY	26,156,937	44,210,190	70,367,127	0.129525	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,207,960	1,355,343	4,563,303	0.389584	62.00
65.00	06500	RESPIRATORY THERAPY	5,907,837	2,790,078	8,697,915	0.417968	65.00
66.00	06600	PHYSICAL THERAPY	4,944,648	1,067,233	6,011,881	0.514496	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,967,961	218,558	3,186,519	0.314541	67.00
68.00	06800	SPEECH PATHOLOGY	1,147,914	532,287	1,680,201	0.277298	68.00
69.00	06900	ELECTROCARDIOLOGY	24,762,160	29,921,551	54,683,711	0.079631	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	218,050	2,506,472	2,724,522	0.227232	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,516,322	22,044,010	44,560,332	0.200116	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,101,758	10,135,120	33,236,878	0.373130	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,339,076	47,226,170	96,565,246	0.214416	73.00
74.00	07400	RENAL DIALYSIS	1,912,045	288,280	2,200,325	0.430286	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	806,633	806,633		88.00
91.00	09100	EMERGENCY	7,784,723	24,289,309	32,074,032	0.326039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,538,744	11,516,406	14,055,150	0.536672	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	5,171,511	5,171,511		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	3,593,326	3,593,326		116.00
200.00		Subtotal (see instructions)	342,354,323	342,166,608	684,520,931		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	342,354,323	342,166,608	684,520,931		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet C
Part I
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		11.00			
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF				41.00
43.00	04300 NURSERY				43.00
44.00	04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.347013			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.687433			52.00
53.00	05300 ANESTHESIOLOGY	0.069036			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.151159			54.00
60.00	06000 LABORATORY	0.129525			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.389584			62.00
65.00	06500 RESPIRATORY THERAPY	0.419179			65.00
66.00	06600 PHYSICAL THERAPY	0.514496			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.314541			67.00
68.00	06800 SPEECH PATHOLOGY	0.277298			68.00
69.00	06900 ELECTROCARDIOLOGY	0.079838			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.229968			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.200116			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.373130			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.214416			73.00
74.00	07400 RENAL DIALYSIS	0.430286			74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
91.00	09100 EMERGENCY	0.332967			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.536672			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
116.00	11600 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: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	38,881,494		38,881,494	0	0 30.00
31.00	03100 INTENSIVE CARE UNIT	9,293,374		9,293,374	0	0 31.00
40.00	04000 SUBPROVIDER - IPF	9,257,598		9,257,598	0	0 40.00
41.00	04100 SUBPROVIDER - IRF	4,086,089		4,086,089	0	0 41.00
43.00	04300 NURSERY	1,001,487		1,001,487	0	0 43.00
44.00	04400 SKILLED NURSING FACILITY	3,885,799		3,885,799	0	0 44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	22,509,218		22,509,218	0	0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,831,316		2,831,316	0	0 52.00
53.00	05300 ANESTHESIOLOGY	931,113		931,113	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	15,264,616		15,264,616	0	0 54.00
60.00	06000 LABORATORY	9,114,281		9,114,281	0	0 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,777,789		1,777,789	0	0 62.00
65.00	06500 RESPIRATORY THERAPY	3,635,446	0	3,635,446	0	0 65.00
66.00	06600 PHYSICAL THERAPY	3,093,087	0	3,093,087	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	1,002,292	0	1,002,292	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	465,917	0	465,917	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	4,354,492		4,354,492	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	619,099		619,099	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8,917,244		8,917,244	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	12,401,668		12,401,668	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	20,705,144		20,705,144	0	0 73.00
74.00	07400 RENAL DIALYSIS	946,770		946,770	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	1,076,949		1,076,949	0	0 88.00
91.00	09100 EMERGENCY	10,457,400		10,457,400	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7,543,009		7,543,009	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	6,827,147		6,827,147		0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
116.00	11600 HOSPICE	3,982,491		3,982,491		0 116.00
200.00	Subtotal (see instructions)	204,862,329	0	204,862,329	0	0 200.00
201.00	Less Observation Beds	7,543,009		7,543,009		0 201.00
202.00	Total (see instructions)	197,319,320	0	197,319,320	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet C
Part I
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		Title XIX			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	55,604,365		55,604,365		30.00
31.00	03100	INTENSIVE CARE UNIT	28,929,735		28,929,735		31.00
40.00	04000	SUBPROVIDER - IPF	20,149,452		20,149,452		40.00
41.00	04100	SUBPROVIDER - IRF	4,875,727		4,875,727		41.00
43.00	04300	NURSERY	2,707,980		2,707,980		43.00
44.00	04400	SKILLED NURSING FACILITY	4,400,105		4,400,105		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	21,727,096	43,357,743	65,084,839	0.345844	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,667,958	450,719	4,118,677	0.687433	52.00
53.00	05300	ANESTHESIOLOGY	5,696,320	7,791,074	13,487,394	0.069036	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,089,450	82,894,595	100,984,045	0.151159	54.00
60.00	06000	LABORATORY	26,156,937	44,210,190	70,367,127	0.129525	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,207,960	1,355,343	4,563,303	0.389584	62.00
65.00	06500	RESPIRATORY THERAPY	5,907,837	2,790,078	8,697,915	0.417968	65.00
66.00	06600	PHYSICAL THERAPY	4,944,648	1,067,233	6,011,881	0.514496	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,967,961	218,558	3,186,519	0.314541	67.00
68.00	06800	SPEECH PATHOLOGY	1,147,914	532,287	1,680,201	0.277298	68.00
69.00	06900	ELECTROCARDIOLOGY	24,762,160	29,921,551	54,683,711	0.079631	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	218,050	2,506,472	2,724,522	0.227232	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,516,322	22,044,010	44,560,332	0.200116	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,101,758	10,135,120	33,236,878	0.373130	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,339,076	47,226,170	96,565,246	0.214416	73.00
74.00	07400	RENAL DIALYSIS	1,912,045	288,280	2,200,325	0.430286	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	806,633	806,633	1.335116	88.00
91.00	09100	EMERGENCY	7,784,723	24,289,309	32,074,032	0.326039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,538,744	11,516,406	14,055,150	0.536672	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	5,171,511	5,171,511		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	3,593,326	3,593,326		116.00
200.00		Subtotal (see instructions)	342,354,323	342,166,608	684,520,931		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	342,354,323	342,166,608	684,520,931		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet C
Part 1
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF				41.00
43.00	04300 NURSERY				43.00
44.00	04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400 RENAL DIALYSIS	0.000000			74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
116.00	11600 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: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part I
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,680,346	0	2,680,346	40,913	65.51	30.00
31.00	03100	INTENSIVE CARE UNIT	727,493		727,493	5,242	138.78	31.00
40.00	04000	SUBPROVIDER - IPF	537,388	0	537,388	11,440	46.97	40.00
41.00	04100	SUBPROVIDER - IRF	265,152	0	265,152	4,949	53.58	41.00
43.00	04300	NURSERY	66,556		66,556	2,483	26.80	43.00
44.00	04400	SKILLED NURSING FACILITY	287,505		287,505	5,710	50.35	44.00
200.00		Total (lines 30-199)	4,564,440		4,564,440	70,737		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part I
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XVIII	Hospital	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00			
30.00	03000 ADULTS & PEDIATRICS	20,812	1,363,394			30.00
31.00	03100 INTENSIVE CARE UNIT	3,100	430,218			31.00
40.00	04000 SUBPROVIDER - IPF	1,925	90,417			40.00
41.00	04100 SUBPROVIDER - IRF	3,480	186,458			41.00
43.00	04300 NURSERY	0	0			43.00
44.00	04400 SKILLED NURSING FACILITY	4,569	230,049			44.00
200.00	Total (lines 30-199)	33,886	2,300,536			200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part II
Date/Time Prepared:
2/28/2013 2:41 pm

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)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,347,574	65,084,839	0.051434	17,006,538	874,714	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	139,409	4,118,677	0.033848	30,848	1,044	52.00
53.00	05300 ANESTHESIOLOGY	176,702	13,487,394	0.013101	2,842,747	37,243	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,274,274	100,984,045	0.032424	15,607,450	506,056	54.00
60.00	06000 LABORATORY	680,927	70,367,127	0.009677	15,676,075	151,697	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	38,426	4,563,303	0.008421	1,582,947	13,330	62.00
65.00	06500 RESPIRATORY THERAPY	188,488	8,697,915	0.021670	5,289,765	114,629	65.00
66.00	06600 PHYSICAL THERAPY	188,340	6,011,881	0.031328	1,511,859	47,364	66.00
67.00	06700 OCCUPATIONAL THERAPY	32,321	3,186,519	0.010143	616,984	6,258	67.00
68.00	06800 SPEECH PATHOLOGY	15,322	1,680,201	0.009119	380,205	3,467	68.00
69.00	06900 ELECTROCARDIOLOGY	986,100	54,683,711	0.018033	13,481,457	243,111	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	70,333	2,724,522	0.025815	120,496	3,111	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	393,561	44,560,332	0.008832	11,229,012	99,175	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	401,389	33,236,878	0.012077	14,377,597	173,638	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	700,769	96,565,246	0.007257	29,817,424	216,385	73.00
74.00	07400 RENAL DIALYSIS	19,171	2,200,325	0.008713	1,500,524	13,074	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	55,745	806,633	0.069108	0	0	88.00
91.00	09100 EMERGENCY	717,320	32,074,032	0.022365	4,428,134	99,035	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	519,909	14,055,150	0.036991	1,844,975	68,247	92.00
200.00	Total (lines 50-199)	11,946,080	559,088,730		137,345,037	2,671,578	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140015		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/28/2013 2:41 pm		
Cost Center Description		Title XVIII			Hospital		PPS	
		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	03000	ADULTS & PEDIATRICS	3,080,373	0	0	0	3,080,373	30.00
31.00	03100	INTENSIVE CARE UNIT	255,124	0	0	0	255,124	31.00
40.00	04000	SUBPROVIDER - IPF	232,766	0	0	0	232,766	40.00
41.00	04100	SUBPROVIDER - IRF	31,544	0	0	0	31,544	41.00
43.00	04300	NURSERY	56,675	0	0	0	56,675	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	3,656,482	0	0	0	3,656,482	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part III
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	Hospital		PPS Nursing School
				Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj.	
	6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	40,913	75.29	20,812	1,566,935		0 30.00
31.00 03100 INTENSIVE CARE UNIT	5,242	48.67	3,100	150,877		0 31.00
40.00 04000 SUBPROVIDER - IPF	11,440	20.35	1,925	39,174		0 40.00
41.00 04100 SUBPROVIDER - IRF	4,949	6.37	3,480	22,168		0 41.00
43.00 04300 NURSERY	2,483	22.83	0	0		0 43.00
44.00 04400 SKILLED NURSING FACILITY	5,710	0.00	4,569	0		0 44.00
200.00 Total (lines 30-199)	70,737		33,886	1,779,154		0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part III Date/Time Prepared: 2/28/2013 2:41 pm
		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	03000 ADULTS & PEDIATRICS	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	31.00
40.00	04000 SUBPROVIDER - IPF	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	41.00
43.00	04300 NURSERY	0	0	43.00
44.00	04400 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: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part IV
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		Title XVIII			Hospital	PPS	Total Cost (sum of col 1 through col 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	206,595	0	0	206,595	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	165,518	0	0	165,518	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	296,190	0	296,190	54.00
60.00	06000	LABORATORY	0	0	104,889	0	104,889	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	26,691	0	0	26,691	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	135,708	0	0	135,708	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	597,504	0	0	597,504	92.00
200.00		Total (lines 50-199)	0	1,132,016	401,079	0	1,533,095	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part IV
Date/Time Prepared:
2/28/2013 2:41 pm

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	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	206,595	65,084,839	0.003174	0.003174	17,006,538	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	165,518	4,118,677	0.040187	0.040187	30,848	52.00
53.00	05300 ANESTHESIOLOGY	0	13,487,394	0.000000	0.000000	2,842,747	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	296,190	100,984,045	0.002933	0.002933	15,607,450	54.00
60.00	06000 LABORATORY	104,889	70,367,127	0.001491	0.001491	15,676,075	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,563,303	0.000000	0.000000	1,582,947	62.00
65.00	06500 RESPIRATORY THERAPY	0	8,697,915	0.000000	0.000000	5,289,765	65.00
66.00	06600 PHYSICAL THERAPY	0	6,011,881	0.000000	0.000000	1,511,859	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	3,186,519	0.000000	0.000000	616,984	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,680,201	0.000000	0.000000	380,205	68.00
69.00	06900 ELECTROCARDIOLOGY	26,691	54,683,711	0.000488	0.000488	13,481,457	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,724,522	0.000000	0.000000	120,496	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	44,560,332	0.000000	0.000000	11,229,012	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	33,236,878	0.000000	0.000000	14,377,597	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	96,565,246	0.000000	0.000000	29,817,424	73.00
74.00	07400 RENAL DIALYSIS	0	2,200,325	0.000000	0.000000	1,500,524	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	806,633	0.000000	0.000000	0	88.00
91.00	09100 EMERGENCY	135,708	32,074,032	0.004231	0.004231	4,428,134	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	597,504	14,055,150	0.042511	0.042511	1,844,975	92.00
200.00	Total (lines 50-199)	1,533,095	559,088,730			137,345,037	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

worksheet D
Part IV
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 3/1	Outpatient Program Charges on/after 3/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 3/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 3/1	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	53,979	7,221,575	10,110,205	22,921	32,090	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,240	2,757	3,859	111	155	52.00
53.00	05300 ANESTHESIOLOGY	0	1,086,744	1,521,441	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	45,777	10,592,221	14,829,110	31,067	43,494	54.00
60.00	06000 LABORATORY	23,373	457,454	640,436	682	955	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	237,655	332,717	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	559,189	782,865	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	118	164	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	521	729	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	6,579	4,545,140	6,363,195	2,218	3,105	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	313,941	439,517	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,474,933	4,864,906	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2,023,815	2,833,341	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7,300,789	10,221,104	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	60,353	84,494	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100 EMERGENCY	18,735	2,305,175	3,227,245	9,753	13,654	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	78,432	2,563,808	3,589,332	108,990	152,586	92.00
200.00	Total (lines 50-199)	228,115	42,746,188	59,844,660	175,742	246,039	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part IV
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		Title XVIII				Hospital		PPS
		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost			
		21.00	22.00	23.00	24.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part V
Date/Time Prepared:
2/28/2013 2:41 pm

		Title XVIII		Hospital		PPS		
Cost Center Description		Cost to Charge Ratio From worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.) before 3/1	PPS Reimbursed Services (see inst.) on/after 3/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		1.00	2.00	2.01	3.00	4.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.345844	7,221,575	10,110,205	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.687433	2,757	3,859	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.069036	1,086,744	1,521,441	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151159	10,592,221	14,829,110	0	0	54.00
60.00	06000	LABORATORY	0.129525	457,454	640,436	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.389584	237,655	332,717	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.417968	559,189	782,865	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.514496	118	164	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.314541	521	729	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.277298	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.079631	4,545,140	6,363,195	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.227232	313,941	439,517	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.200116	3,474,933	4,864,906	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.373130	2,023,815	2,833,341	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214416	7,300,789	10,221,104	0	145,305	73.00
74.00	07400	RENAL DIALYSIS	0.430286	60,353	84,494	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
91.00	09100	EMERGENCY	0.326039	2,305,175	3,227,245	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.536672	2,563,808	3,589,332	0	0	92.00
200.00		Subtotal (see instructions)		42,746,188	59,844,660	0	145,305	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		42,746,188	59,844,660	0	145,305	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140015	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/28/2013 2:41 pm
		Title XVIII	Hospital	PPS

Cost Center Description		Costs					
		PPS Services (see inst.) before 3/1	PPS Services (see inst.) on/after 3/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		5.00	5.01	6.00	7.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,497,538	3,496,554	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,895	2,653	0	0	52.00
53.00	05300	ANESTHESIOLOGY	75,024	105,034	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,601,110	2,241,553	0	0	54.00
60.00	06000	LABORATORY	59,252	82,952	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	92,587	129,621	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	233,723	327,213	0	0	65.00
66.00	06600	PHYSICAL THERAPY	61	84	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	164	229	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	361,934	506,708	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	71,337	99,872	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	695,390	973,546	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	755,146	1,057,205	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,565,406	2,191,568	0	31,156	73.00
74.00	07400	RENAL DIALYSIS	25,969	36,357	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00	09100	EMERGENCY	751,577	1,052,208	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,375,924	1,926,294	0	0	92.00
200.00		Subtotal (see instructions)	10,164,037	14,229,651	0	31,156	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0		201.00
202.00		Net Charges (line 200 +/- line 201)	10,164,037	14,229,651	0	31,156	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140015
Component CCN: 14S015

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part II
Date/Time Prepared:
2/28/2013 2:41 pm

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	05000	OPERATING ROOM	3,347,574	65,084,839	0.051434	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	139,409	4,118,677	0.033848	0	52.00
53.00	05300	ANESTHESIOLOGY	176,702	13,487,394	0.013101	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,274,274	100,984,045	0.032424	71,172	54.00
60.00	06000	LABORATORY	680,927	70,367,127	0.009677	389,652	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	38,426	4,563,303	0.008421	0	62.00
65.00	06500	RESPIRATORY THERAPY	188,488	8,697,915	0.021670	14,143	65.00
66.00	06600	PHYSICAL THERAPY	188,340	6,011,881	0.031328	2,096	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,321	3,186,519	0.010143	593	67.00
68.00	06800	SPEECH PATHOLOGY	15,322	1,680,201	0.009119	0	68.00
69.00	06900	ELECTROCARDIOLOGY	986,100	54,683,711	0.018033	30,561	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70,333	2,724,522	0.025815	743	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	393,561	44,560,332	0.008832	8,187	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	401,389	33,236,878	0.012077	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	700,769	96,565,246	0.007257	208,460	73.00
74.00	07400	RENAL DIALYSIS	19,171	2,200,325	0.008713	4,326	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	55,745	806,633	0.069108	0	88.00
91.00	09100	EMERGENCY	717,320	32,074,032	0.022365	120,373	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	14,055,150	0.000000	0	92.00
200.00		Total (lines 50-199)	11,426,171	559,088,730		850,306	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015
Component CCN: 14S015

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part IV
Date/Time Prepared:
2/28/2013 2:41 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	206,595	0	0	206,595	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	165,518	0	0	165,518	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	296,190	0	296,190	54.00
60.00	06000 LABORATORY	0	0	104,889	0	104,889	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	26,691	0	0	26,691	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100 EMERGENCY	0	135,708	0	0	135,708	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (Lines 50-199)	0	534,512	401,079	0	935,591	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part IV
Date/Time Prepared:
2/28/2013 2:41 pm

Component CCN: 14S015

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	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	206,595	65,084,839	0.003174	0.003174	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	165,518	4,118,677	0.040187	0.040187	0	52.00
53.00	05300 ANESTHESIOLOGY	0	13,487,394	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	296,190	100,984,045	0.002933	0.002933	71,172	54.00
60.00	06000 LABORATORY	104,889	70,367,127	0.001491	0.001491	389,652	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,563,303	0.000000	0.000000	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	8,697,915	0.000000	0.000000	14,143	65.00
66.00	06600 PHYSICAL THERAPY	0	6,011,881	0.000000	0.000000	2,096	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	3,186,519	0.000000	0.000000	593	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,680,201	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	26,691	54,683,711	0.000488	0.000488	30,561	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,724,522	0.000000	0.000000	743	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	44,560,332	0.000000	0.000000	8,187	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	33,236,878	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	96,565,246	0.000000	0.000000	208,460	73.00
74.00	07400 RENAL DIALYSIS	0	2,200,325	0.000000	0.000000	4,326	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	806,633	0.000000	0.000000	0	88.00
91.00	09100 EMERGENCY	135,708	32,074,032	0.004231	0.004231	120,373	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	14,055,150	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	935,591	559,088,730			850,306	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015
Component CCN: 14S015

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part IV
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 3/1	Outpatient Program Charges on/after 3/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 3/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 3/1	
		11.00	12.00	12.01	13.00	13.01	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	209	4,326	0	13	0	54.00
60.00	06000 LABORATORY	581	0	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	15	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	779	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100 EMERGENCY	509	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	1,314	5,105	0	13	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015
Component CCN: 14S015

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part IV
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		21.00	22.00	23.00	24.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00	09100 EMERGENCY	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140015	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/28/2013 2:41 pm	
		Component CCN: 14S015	Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			
		PPS Reimbursed Services (see Inst.) before 3/1	PPS Reimbursed Services (see Inst.) on/after 3/1	Cost Reimbursed Services Subject To Ded. & Coins. (see Inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see Inst.)
	1.00	2.00	2.01	3.00	4.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.345844	0	0	0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.687433	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.069036	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.151159	4,326	0	0 54.00
60.00	06000 LABORATORY	0.129525	0	0	0 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.389584	0	0	0 62.00
65.00	06500 RESPIRATORY THERAPY	0.417968	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.514496	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.314541	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.277298	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.079631	0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.227232	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.200116	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.373130	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.214416	779	0	0 73.00
74.00	07400 RENAL DIALYSIS	0.430286	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			0 88.00
91.00	09100 EMERGENCY	0.326039	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.536672	0	0	0 92.00
200.00	Subtotal (see instructions)		5,105	0	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0 201.00
202.00	Net Charges (line 200 +/- line 201)		5,105	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140015 Component CCN: 14S015		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part V Date/Time Prepared: 2/28/2013 2:41 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Costs						
	PPS Services (see inst.) before 3/1	PPS Services (see inst.) on/after 3/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	5.00	5.01	6.00	7.00			
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	0	0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	654	0	0	0	54.00	
60.00	06000 LABORATORY	0	0	0	0	60.00	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00	
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	65.00	
66.00	06600 PHYSICAL THERAPY	0	0	0	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	167	0	0	0	73.00	
74.00	07400 RENAL DIALYSIS	0	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	88.00	
91.00	09100 EMERGENCY	0	0	0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00	
200.00	Subtotal (see instructions)	821	0	0	0	200.00	
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00	
202.00	Net Charges (line 200 +/- line 201)	821	0	0	0	202.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140015

Period: From 10/01/2011

Worksheet D

Component CCN: 14T015

To 09/30/2012

Part II

Date/Time Prepared: 2/28/2013 2:41 pm

Title XVIII

Subprovider - IRF

PPS

Cost Center Description		Capital Related Cost (From Wkst. B, Part II, col. 26)	Total Charges (From Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,347,574	65,084,839	0.051434	18,497	951	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	139,409	4,118,677	0.033848	0	0	52.00
53.00	05300 ANESTHESIOLOGY	176,702	13,487,394	0.013101	3,444	45	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,274,274	100,984,045	0.032424	314,783	10,207	54.00
60.00	06000 LABORATORY	680,927	70,367,127	0.009677	426,716	4,129	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	38,426	4,563,303	0.008421	21,633	182	62.00
65.00	06500 RESPIRATORY THERAPY	188,488	8,697,915	0.021670	92,109	1,996	65.00
66.00	06600 PHYSICAL THERAPY	188,340	6,011,881	0.031328	1,292,391	40,488	66.00
67.00	06700 OCCUPATIONAL THERAPY	32,321	3,186,519	0.010143	974,487	9,884	67.00
68.00	06800 SPEECH PATHOLOGY	15,322	1,680,201	0.009119	319,130	2,910	68.00
69.00	06900 ELECTROCARDIOLOGY	986,100	54,683,711	0.018033	31,858	574	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	70,333	2,724,522	0.025815	5,946	153	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	393,561	44,560,332	0.008832	108,710	960	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	401,389	33,236,878	0.012077	10,755	130	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	700,769	96,565,246	0.007257	875,414	6,353	73.00
74.00	07400 RENAL DIALYSIS	19,171	2,200,325	0.008713	99,491	867	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	55,745	806,633	0.069108	0	0	88.00
91.00	09100 EMERGENCY	717,320	32,074,032	0.022365	16,992	380	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	14,055,150	0.000000	0	0	92.00
200.00	Total (lines 50-199)	11,426,171	559,088,730		4,612,356	80,209	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015
Component CCN: 14T015

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part IV
Date/Time Prepared:
2/28/2013 2:41 pm

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	05000 OPERATING ROOM	0	206,595	0	0	206,595	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	165,518	0	0	165,518	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	296,190	0	296,190	54.00
60.00	06000 LABORATORY	0	0	104,889	0	104,889	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	26,691	0	0	26,691	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100 EMERGENCY	0	135,708	0	0	135,708	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	534,512	401,079	0	935,591	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/28/2013 2:41 pm
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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	05000 OPERATING ROOM	206,595	65,084,839	0.003174	0.003174	18,497	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	165,518	4,118,677	0.040187	0.040187	0	52.00
53.00	05300 ANESTHESIOLOGY	0	13,487,394	0.000000	0.000000	3,444	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	296,190	100,984,045	0.002933	0.002933	314,783	54.00
60.00	06000 LABORATORY	104,889	70,367,127	0.001491	0.001491	426,716	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,563,303	0.000000	0.000000	21,633	62.00
65.00	06500 RESPIRATORY THERAPY	0	8,697,915	0.000000	0.000000	92,109	65.00
66.00	06600 PHYSICAL THERAPY	0	6,011,881	0.000000	0.000000	1,292,391	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	3,186,519	0.000000	0.000000	974,487	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,680,201	0.000000	0.000000	319,130	68.00
69.00	06900 ELECTROCARDIOLOGY	26,691	54,683,711	0.000488	0.000488	31,858	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,724,522	0.000000	0.000000	5,946	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	44,560,332	0.000000	0.000000	108,710	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	33,236,878	0.000000	0.000000	10,755	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	96,565,246	0.000000	0.000000	875,414	73.00
74.00	07400 RENAL DIALYSIS	0	2,200,325	0.000000	0.000000	99,491	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	806,633	0.000000	0.000000	0	88.00
91.00	09100 EMERGENCY	135,708	32,074,032	0.004231	0.004231	16,992	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	14,055,150	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	935,591	559,088,730			4,612,356	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/28/2013 2:41 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 3/1	Outpatient Program Charges on/after 3/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 3/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 3/1	
		11.00	12.00	12.01	13.00	13.01	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	59	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	923	0	0	0	54.00
60.00	06000	LABORATORY	636	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	16	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00	09100	EMERGENCY	72	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (Lines 50-199)	1,706	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140015 Component CCN: 14T015		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part IV Date/Time Prepared: 2/28/2013 2:41 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		21.00	22.00	23.00	24.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0	0		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0		62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0		88.00
91.00	09100 EMERGENCY	0	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0		92.00
200.00	Total (Lines 50-199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015
Component CCN: 145643

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part IV
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	Skilled Nursing Facility	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
		1.00	2.00	3.00		4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0	206,595	0	0	0	206,595	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	165,518	0	0	0	165,518	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	296,190	0	0	296,190	54.00
60.00	06000 LABORATORY	0	0	104,889	0	0	104,889	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	26,691	0	0	0	26,691	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
91.00	09100 EMERGENCY	0	135,708	0	0	0	135,708	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	534,512	401,079	0	0	935,591	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015
Component CCN: 145643

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part IV
Date/Time Prepared:
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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	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	206,595	65,084,839	0.003174	0.003174	22,006	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	165,518	4,118,677	0.040187	0.040187	0	52.00
53.00	05300 ANESTHESIOLOGY	0	13,487,394	0.000000	0.000000	993	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	296,190	100,984,045	0.002933	0.002933	154,090	54.00
60.00	06000 LABORATORY	104,889	70,367,127	0.001491	0.001491	672,555	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,563,303	0.000000	0.000000	50,748	62.00
65.00	06500 RESPIRATORY THERAPY	0	8,697,915	0.000000	0.000000	196,107	65.00
66.00	06600 PHYSICAL THERAPY	0	6,011,881	0.000000	0.000000	984,410	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	3,186,519	0.000000	0.000000	674,189	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,680,201	0.000000	0.000000	118,348	68.00
69.00	06900 ELECTROCARDIOLOGY	26,691	54,683,711	0.000488	0.000488	43,508	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,724,522	0.000000	0.000000	4,460	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	44,560,332	0.000000	0.000000	289,139	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	33,236,878	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	96,565,246	0.000000	0.000000	1,693,810	73.00
74.00	07400 RENAL DIALYSIS	0	2,200,325	0.000000	0.000000	86,514	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	806,633	0.000000	0.000000	0	88.00
91.00	09100 EMERGENCY	135,708	32,074,032	0.004231	0.004231	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	14,055,150	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	935,591	559,088,730			4,990,877	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015
Component CCN: 145643

Period:
From 10/01/2011
To 09/30/2012

worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 3/1	Outpatient Program Charges on/after 3/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 3/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 3/1	PPS
		11.00	12.00	12.01	13.00	13.01	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	70	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	452	0	0	0	0	54.00
60.00	06000 LABORATORY	1,003	0	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	21	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	1,546	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/28/2013 2:41 pm	
		Title XVIII		Skilled Nursing Facility	PPS
Cost Center Description	PSA Adj. Non-Physician Anesthetist Cost	PSA Adj. Nursing School	PSA Adj. Allied Health	PSA Adj. All-Other Medical Education Cost	
	21.00	22.00	23.00	24.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet D-1

Date/Time Prepared:
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Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			40,913 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			40,913 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			32,977 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)			20,812 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)			38,887,186 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)			38,887,186 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			54,717,297 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			54,717,297 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.710693 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)			1,659.26 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)			38,887,186 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)			950.48 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			19,781,390 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)			19,781,390 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet D-1

Date/Time Prepared:
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Cost Center Description		Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 + col. 2)		(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	9,307,248	5,242	1,775.51	3,100	5,504,081	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					32,639,406	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					57,924,877	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)					3,511,424	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					2,899,693	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					6,411,117	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					51,513,760	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)					7,936	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					950.48	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					7,543,009	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

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Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Hospital		
				Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	2,680,346	38,887,186	0.068926	7,543,009	519,909	90.00
91.00 Nursing School cost	3,080,373	38,887,186	0.079213	7,543,009	597,504	91.00
92.00 Allied health cost	0	38,887,186	0.000000	7,543,009	0	92.00
93.00 All other Medical Education	0	38,887,186	0.000000	7,543,009	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015

Period: From 10/01/2011

Worksheet D-1

Component CCN: 14S015

To 09/30/2012

Date/Time Prepared: 2/28/2013 2:41 pm

Title XVIII

Subprovider - IPF

PPS

Cost Center Description

1.00

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,440	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,440	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	11,440	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,925	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00

SWING BED ADJUSTMENT

17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,257,598	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)	9,257,598	27.00

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28.00	General inpatient routine service charges (excluding swing-bed charges)	20,278,787	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	20,278,787	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.456516	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)	1,772.62	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)	9,257,598	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)	809.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,557,768	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,557,768	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015

Period: From 10/01/2011

Worksheet D-1

Component CCN: 14S015

To 09/30/2012

Date/Time Prepared: 2/28/2013 2:41 pm

Title XVIII		Subprovider - IPF		PPS		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					159,308	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,717,076	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)					129,591	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					12,656	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					142,247	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,574,829	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015
Component CCN: 14S015

Period:
From 10/01/2011
To 09/30/2012

Worksheet D-1
Date/Time Prepared:
2/28/2013 2:41 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description	Cost	Routine Cost (From line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	537,388	9,257,598	0.058048	0	0	90.00
91.00 Nursing School cost	232,766	9,257,598	0.025143	0	0	91.00
92.00 Allied health cost	0	9,257,598	0.000000	0	0	92.00
93.00 All other Medical Education	0	9,257,598	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015

Period: From 10/01/2011

Worksheet D-1

Component CCN: 14T015

To 09/30/2012

Date/Time Prepared: 2/28/2013 2:41 pm

Title XVIII

Subprovider - IRF

PPS

Cost Center Description		1.00	
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,949	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,949	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,949	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)	3,480	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)	4,101,807	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)	4,101,807	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)	4,961,175	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	4,961,175	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.826781	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)	1,002.46	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)	4,101,807	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)	828.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,884,294	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)	2,884,294	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015 Component CCN: 14T015		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/28/2013 2:41 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,482,336	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,366,630	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)					208,626	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					81,915	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					290,541	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,076,089	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015
Component CCN: 14T015

Period:
From 10/01/2011
To 09/30/2012

Worksheet D-1
Date/Time Prepared:
2/28/2013 2:41 pm
PPS

Title XVIII

Subprovider -
IRF

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	265,152	4,101,807	0.064643	0	0	90.00
91.00 Nursing School cost	31,544	4,101,807	0.007690	0	0	91.00
92.00 Allied health cost	0	4,101,807	0.000000	0	0	92.00
93.00 All other Medical Education	0	4,101,807	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015

Period: From 10/01/2011

Worksheet D-1

Component CCN: 145643

To 09/30/2012

Date/Time Prepared: 2/28/2013 2:41 pm

Title XVIII

Skilled Nursing Facility

PPS

Cost Center Description

1.00

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,710	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,710	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,710	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,569	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)	3,886,281	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)	3,886,281	27.00

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28.00	General inpatient routine service charges (excluding swing-bed charges)	4,448,743	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	4,448,743	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.873568	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)	779.11	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)	3,886,281	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: 140015
Component CCN: 145643

Period:
From 10/01/2011
To 09/30/2012

Worksheet D-1
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		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							
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1.00	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					3,886,281	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					680.61	71.00
72.00	Program routine service cost (line 9 x line 71)					3,109,707	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)					3,109,707	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)					3,109,707	83.00
84.00	Program inpatient ancillary services (see instructions)					1,433,920	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)					4,543,627	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: 140015
Component CCN: 145643

Period:
From 10/01/2011
To 09/30/2012

Worksheet D-1
Date/Time Prepared:
2/28/2013 2:41 pm

Title XVIII

Skilled Nursing
Facility

PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet D-3

Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		Title XVIII	Hospital	PPS
		Ratio of cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		35,655,309	30.00
31.00	03100 INTENSIVE CARE UNIT		18,594,934	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		0	41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.347013	17,006,538	5,901,490 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.687433	30,848	21,206 52.00
53.00	05300 ANESTHESIOLOGY	0.069036	2,842,747	196,252 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.151159	15,607,450	2,359,207 54.00
60.00	06000 LABORATORY	0.129525	15,676,075	2,030,444 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.389584	1,582,947	616,691 62.00
65.00	06500 RESPIRATORY THERAPY	0.419179	5,289,765	2,217,358 65.00
66.00	06600 PHYSICAL THERAPY	0.514496	1,511,859	777,845 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.314541	616,984	194,067 67.00
68.00	06800 SPEECH PATHOLOGY	0.277298	380,205	105,430 68.00
69.00	06900 ELECTROCARDIOLOGY	0.079838	13,481,457	1,076,333 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.229968	120,496	27,710 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.200116	11,229,012	2,247,105 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.373130	14,377,597	5,364,713 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.214416	29,817,424	6,393,333 73.00
74.00	07400 RENAL DIALYSIS	0.430286	1,500,524	645,654 74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		0 88.00
91.00	09100 EMERGENCY	0.332967	4,428,134	1,474,422 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.536672	1,844,975	990,146 92.00
200.00	Total (sum of lines 50-94 and 96-98)		137,345,037	32,639,406 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net Charges (line 200 minus line 201)		137,345,037	32,639,406 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140015

Period: From 10/01/2011

Worksheet D-3

Component CCN: 14S015

To 09/30/2012

Date/Time Prepared: 2/28/2013 2:41 pm

Title XVIII

Subprovider - IPF

PPS

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		3,379,384		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.347013	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.687433	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.069036	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.151159	71,172	10,758	54.00
60.00	06000 LABORATORY	0.129525	389,652	50,470	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.389584	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.419179	14,143	5,928	65.00
66.00	06600 PHYSICAL THERAPY	0.514496	2,096	1,078	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.314541	593	187	67.00
68.00	06800 SPEECH PATHOLOGY	0.277298	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.079838	30,561	2,440	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.229968	743	171	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.200116	8,187	1,638	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.373130	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.214416	208,460	44,697	73.00
74.00	07400 RENAL DIALYSIS	0.430286	4,326	1,861	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.332967	120,373	40,080	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.536672	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		850,306	159,308	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)		850,306		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2011 To 09/30/2012	worksheet D-3 Date/Time Prepared: 2/28/2013 2:41 pm
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	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		3,449,657	41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.347013	18,497	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.687433	0	52.00
53.00	05300 ANESTHESIOLOGY	0.069036	3,444	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.151159	314,783	54.00
60.00	06000 LABORATORY	0.129525	426,716	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.389584	21,633	62.00
65.00	06500 RESPIRATORY THERAPY	0.419179	92,109	65.00
66.00	06600 PHYSICAL THERAPY	0.514496	1,292,391	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.314541	974,487	67.00
68.00	06800 SPEECH PATHOLOGY	0.277298	319,130	68.00
69.00	06900 ELECTROCARDIOLOGY	0.079838	31,858	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.229968	5,946	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.200116	108,710	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.373130	10,755	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.214416	875,414	73.00
74.00	07400 RENAL DIALYSIS	0.430286	99,491	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100 EMERGENCY	0.332967	16,992	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.536672	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,612,356	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		4,612,356	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/28/2013 2:41 pm
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	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		0	41.00
43.00	04300 NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.345844	22,006	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.687433	0	52.00
53.00	05300 ANESTHESIOLOGY	0.069036	993	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.151159	154,090	54.00
60.00	06000 LABORATORY	0.129525	672,555	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.389584	50,748	62.00
65.00	06500 RESPIRATORY THERAPY	0.417968	196,107	65.00
66.00	06600 PHYSICAL THERAPY	0.514496	984,410	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.314541	674,189	67.00
68.00	06800 SPEECH PATHOLOGY	0.277298	118,348	68.00
69.00	06900 ELECTROCARDIOLOGY	0.079631	43,508	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.227232	4,460	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.200116	289,139	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.373130	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.214416	1,693,810	73.00
74.00	07400 RENAL DIALYSIS	0.430286	86,514	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	88.00
91.00	09100 EMERGENCY	0.326039	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.536672	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,990,877	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		4,990,877	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet E
Part A
Date/Time Prepared:
2/28/2013 2:41 pm

		Title XVIII		Hospital	PPS
				before 1/1	on/after 1/1
				1.00	1.01
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS					
1.00	DRG Amounts Other than Outlier Payments			37,840,689	1.00
2.00	Outlier payments for discharges. (see instructions)			1,438,693	2.00
2.01	Outlier reconciliation amount			0	2.01
3.00	Managed Care Simulated Payments			1,141,994	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			167.32	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)			19.50	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)			19.50	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			16.71	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)			16.71	12.00
13.00	Total allowable FTE count for the prior year.			14.45	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.			13.16	14.00
15.00	Sum of lines 12 through 14 divided by 3.			14.77	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			14.77	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.088274	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.084552	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.084552	21.00
22.00	IME payment adjustment (see instructions)			1,758,743	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 --, 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)			1,758,743	29.00
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			4.26	30.00
31.00	Percentage of Medicaid patient days to total days reported on worksheet S-2, Part I, line 24. (see instructions)			10.79	31.00
32.00	Sum of lines 30 and 31			15.05	32.00
33.00	Allowable disproportionate share percentage (see instructions)			2.53	33.00
34.00	Disproportionate share adjustment (see instructions)			957,369	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 and 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 and 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)			41,995,494	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)			46,525,402	48.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet E
Part A
Date/Time Prepared:
2/28/2013 2:41 pm

		Title XVIII		Hospital		PPS	
		before 1/1	on/after 1/1	before 1/1	on/after 1/1	before 1/1	on/after 1/1
		1.00				1.01	
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)			46,525,402			49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)			3,315,216			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).			549,388			52.00
53.00	Nursing and Allied Health Managed Care payment			35,698			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 (from wkst D, Part III, column 9, lines 30-35).			1,717,812			57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			228,115			58.00
59.00	Total (sum of amounts on lines 49 through 58)			52,371,631			59.00
60.00	Primary payer payments			16,117			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			52,355,514			61.00
62.00	Deductibles billed to program beneficiaries			4,331,152			62.00
63.00	Coinsurance billed to program beneficiaries			180,663			63.00
64.00	Allowable bad debts (see instructions)			962,982			64.00
65.00	Adjusted reimbursable bad debts (see instructions)			674,087			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			962,982			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			48,517,786			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 (sum of lines 93, 95 and 96).(For SCH see instructions)			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)			48,517,786			71.00
72.00	Interim payments			48,511,454			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)			6,332			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 (see instructions)			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: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet E
Part B
Date/Time Prepared:
2/28/2013 2:41 pm

		Title XVIII		Hospital	PPS
				before 3/1	on/after 3/1
				1.00	1.01
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			31,156	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			9,988,295	13,983,612 2.00
3.00	PPS payments			8,756,165	12,258,631 3.00
4.00	Outlier payment (see instructions)			23,486	32,880 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.897	0.897 5.00
6.00	Line 2 times line 5			8,959,501	12,543,300 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			97.99	97.99 7.00
8.00	Transitional corridor payment (see instructions)			152,873	0 8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200			421,781	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			31,156	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			145,305	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)			145,305	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)			145,305	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			114,149	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)			31,156	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)			21,645,816	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)			4,877,583	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)			16,799,389	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)			196,877	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)			16,996,266	30.00
31.00	Primary payer payments			1,849	31.00
32.00	Subtotal (line 30 minus line 31)			16,994,417	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)			986,867	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			690,807	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			986,867	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			17,685,224	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)			17,685,224	40.00
41.00	Interim payments			17,350,563	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)			334,661	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: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet E
Part B
Date/Time Prepared:
2/28/2013 2:41 pm

		Title XVIII	Hospital	PPS
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	override of Ancillary service charges (line 12)			0112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140015
Component CCN: 14S015

Period:
From 10/01/2011
To 09/30/2012

Worksheet E
Part B
Date/Time Prepared:
2/28/2013 2:41 pm

Title XVIII

Subprovider -

PPS

before 3/1	on/after 3/1
1.00	1.01

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)	808	2.00
3.00	PPS payments	1,011	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200	13	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)	1,024	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)	169	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)	855	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)	855	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	855	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)	855	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)	855	40.00
41.00	Interim payments	843	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)	12	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: 140015
Component CCN: 14S015

Period:
From 10/01/2011
To 09/30/2012

Worksheet E
Part B
Date/Time Prepared:
2/28/2013 2:41 pm

Title XVIII

Subprovider -
IPF

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: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
2/28/2013 2:41 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		48,324,001		17,091,412	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	06/08/2012	223,790	06/08/2012	280,551	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	09/25/2012	36,337	09/25/2012	21,400	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)		187,453		259,151	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)		48,511,454		17,350,563	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		6,332		334,661	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		48,517,786		17,685,224	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: 140015

Period: From 10/01/2011

Worksheet E-1

Component CCN: 14S015

To 09/30/2012

Part I

Date/Time Prepared: 2/28/2013 2:41 pm

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		1,293,468		843
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
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)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	06/08/2012	34,868		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		34,868		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		1,328,336		843
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		5,620		12
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		1,333,956		855
				Contractor Number	Date (Mo/Day/Yr)
				1.00	2.00
8.00	Name of Contractor				

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140015
Component CCN: 14T015

Period:
From 10/01/2011
To 09/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
2/28/2013 2:41 pm

		Title XVIII		Subprovider - TRF		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		5,305,504		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)		5,305,504		0		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0		6.01
6.02	SETTLEMENT TO PROGRAM		51,044		0		6.02
7.00	Total Medicare program liability (see instructions)		5,254,460		0		7.00
				Contractor Number	Date (Mo/Day/Yr)		
				0	1.00	2.00	
8.00	Name of Contractor						

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140015
Component CCN: 145643

Period:
From 10/01/2011
To 09/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
2/28/2013 2:41 pm

		Title XVIII		Skilled Nursing Facility		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,565,052		0		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		1,565,052		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		1,546		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		1,566,598		0		7.00
				Contractor Number	Date (Mo/Day/Yr)		
				0	1.00	2.00	
8.00	Name of Contractor						

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 140015	Period: From 10/01/2011 To 09/30/2012	worksheet E-1 Part II Date/Time Prepared: 2/28/2013 2:41 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from wkst S-3, Part I column 15 line 14			10,054 1.00
2.00	Medicare days from wkst S-3, Part I, column 6 sum of lines 1, 8-12			23,912 2.00
3.00	Medicare HMO days from wkst S-3, Part I, column 6. line 2			650 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			38,219 4.00
5.00	Total hospital charges from wkst C, Part I, column 8 line 200			684,520,931 5.00
6.00	Total hospital charity care charges from wkst S-10, column 3 line 20			63,906,211 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology worksheet s-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			2,010,093 8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			2,010,093 32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140015
Component CCN: 14S015

Period:
From 10/01/2011
To 09/30/2012

Worksheet E-3
Part II
Date/Time Prepared:
2/28/2013 2:41 pm

Title XVIII

Subprovider -
IPF

PPS

		1.00	
PART II - MEDICARE PART A SERVICES - IPF PPS			
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,543,243	1.00
2.00	Net IPF PPS Outlier Payments	1,741	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	31.256831	9.00
10.00	Medical Education Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.	0.000000	10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,544,984	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition	0	14.00
15.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,544,984	16.00
17.00	Primary payer payments	1,080	17.00
18.00	Subtotal (line 16 less line 17).	1,543,904	18.00
19.00	Deductibles	219,572	19.00
20.00	Subtotal (line 18 minus line 19)	1,324,332	20.00
21.00	Coinsurance	30,864	21.00
22.00	Subtotal (line 20 minus line 21)	1,293,468	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,293,468	26.00
27.00	Direct graduate medical education payments (from worksheet E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	40,488	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,333,956	31.00
32.00	Interim payments	1,328,336	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)	5,620	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	35.00
TO BE COMPLETED BY CONTRACTOR			
50.00	Original outlier amount from worksheet E-3, Part II, line 2	1,741	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140015	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part III Date/Time Prepared: 2/28/2013 2:41 pm
		Component CCN: 14T015	Title XVIII	Subprovider - IRF
				PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			5,079,995 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0063 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			155,839 3.00
4.00	Outlier Payments			45,769 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			13.521858 10.00
11.00	Medical Education Adjustment Factor $\{((1 + (\text{line 9}/\text{line 10})) \text{ raised to the power of } .6876 - 1)\}$.			0.000000 11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).			0 12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)			5,281,603 13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)			0 14.00
15.00	Organ acquisition			0 15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 16.00
17.00	Subtotal (see instructions)			5,281,603 17.00
18.00	Primary payer payments			4,884 18.00
19.00	Subtotal (line 17 less line 18).			5,276,719 19.00
20.00	Deductibles			27,576 20.00
21.00	Subtotal (line 19 minus line 20)			5,249,143 21.00
22.00	Coinsurance			18,557 22.00
23.00	Subtotal (line 21 minus line 22)			5,230,586 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			5,230,586 27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			23,874 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			5,254,460 32.00
33.00	Interim payments			5,305,504 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus the sum lines 33 and 34)			-51,044 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from worksheet E-3, Part III, line 4			45,769 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140015	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part VI Date/Time Prepared: 2/28/2013 2:41 pm
Component CCN: 145643	Title XVIII	Skilled Nursing Facility PPS

		1.00	
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES			
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)			
1.00	Resource Utilization Group Payment (RUGS)	1,637,508	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	1,546	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,639,054	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	72,456	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Allowable reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	1,566,598	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)	1,566,598	15.00
16.00	Interim payments	1,565,052	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)	1,546	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140015	Period: From 10/01/2011 To 09/30/2012	Worksheet E-4 Date/Time Prepared: 2/28/2013 2:41 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			19.50	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 plus line 4.02 plus applicable subscripts)			19.50	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			16.71	6.00
7.00	Enter the lesser of line 5 or line 6			16.71	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	16.71	0.00	16.71	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	16.71	0.00	16.71	9.00
10.00	weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	16.71	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	18.26	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	17.83	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	17.60	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	17.60	0.00		17.00
18.00	Per resident amount	77,504.40	0.00		18.00
19.00	Approved amount for resident costs	1,364,077	0	1,364,077	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,364,077	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days	29,317	650		26.00
27.00	Total Inpatient Days (see instructions)	54,608	54,608		27.00
28.00	Ratio of inpatient days to total inpatient days	0.536863	0.011903		28.00
29.00	Program direct GME amount	732,322	16,237		29.00
30.00	Reduction for direct GME payments for Medicare managed care		2,294		30.00
31.00	Net Program direct GME amount			746,265	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 140015	Period: From 10/01/2011 To 09/30/2012	Worksheet E-4 Date/Time Prepared: 2/28/2013 2:41 pm
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	Title XVIII	Hospital	PPS	
			1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Worksheet C, Part I, column 8, sum of lines 74 and 94)		2,200,325	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		68,757,344	37.00
38.00	Organ acquisition costs (Worksheet D-4, Part III, column 1, line 69)		0	38.00
39.00	Cost of teaching physicians (Worksheet D-5, Part II, column 3, line 20)		0	39.00
40.00	Primary payer payments (see instructions)		22,081	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		68,735,263	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		24,633,527	42.00
43.00	Primary payer payments (see instructions)		1,849	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		24,631,678	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		93,366,941	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.736184	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.263816	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		746,265	48.00
49.00	Part A Medicare GME payment (line 46 x 48)(title XVIII only)(see instructions)		549,388	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		196,877	50.00

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

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet G

Date/Time Prepared:
2/28/2013 2:41 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00	Cash on hand in banks	79,642,662	0	0	0 1.00
2.00	Temporary investments	77,698,283	0	0	0 2.00
3.00	Notes receivable	0	0	0	0 3.00
4.00	Accounts receivable	156,542,995	0	0	0 4.00
5.00	Other receivable	7,954,813	0	0	0 5.00
6.00	Allowances for uncollectible notes and accounts receivable	-101,253,757	0	0	0 6.00
7.00	Inventory	6,374,352	0	0	0 7.00
8.00	Prepaid expenses	4,849,977	0	0	0 8.00
9.00	Other current assets	163,286	0	0	0 9.00
10.00	Due from other funds	879,344	0	0	0 10.00
11.00	Total current assets (sum of lines 1-10)	232,851,955	0	0	0 11.00
FIXED ASSETS					
12.00	Land	12,613,855	0	0	0 12.00
13.00	Land improvements	6,408,794	0	0	0 13.00
14.00	Accumulated depreciation	-4,477,859	0	0	0 14.00
15.00	Buildings	143,877,013	0	0	0 15.00
16.00	Accumulated depreciation	-58,024,255	0	0	0 16.00
17.00	Leasehold improvements	1,868,704	0	0	0 17.00
18.00	Accumulated depreciation	-28,700,439	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	133,974,622	0	0	0 23.00
24.00	Accumulated depreciation	-99,071,665	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)	108,468,770	0	0	0 30.00
OTHER ASSETS					
31.00	Investments	14,551,405	0	0	0 31.00
32.00	Deposits on leases	0	0	0	0 32.00
33.00	Due from owners/officers	0	0	0	0 33.00
34.00	Other assets	9,950,636	0	0	0 34.00
35.00	Total other assets (sum of lines 31-34)	24,502,041	0	0	0 35.00
36.00	Total assets (sum of lines 11, 30, and 35)	365,822,766	0	0	0 36.00
CURRENT LIABILITIES					
37.00	Accounts payable	14,718,319	0	0	0 37.00
38.00	Salaries, wages, and fees payable	16,536,478	0	0	0 38.00
39.00	Payroll taxes payable	2,151,781	0	0	0 39.00
40.00	Notes and loans payable (short term)	3,580,000	0	0	0 40.00
41.00	Deferred income	1,111,105	0	0	0 41.00
42.00	Accelerated payments	0	0	0	0 42.00
43.00	Due to other funds	0	0	0	0 43.00
44.00	Other current liabilities	10,168,836	0	0	0 44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	48,266,519	0	0	0 45.00
LONG TERM LIABILITIES					
46.00	Mortgage payable	77,721,489	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	91,210,077	0	0	0 49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	168,931,566	0	0	0 50.00
51.00	Total liabilities (sum of lines 45 and 50)	217,198,085	0	0	0 51.00
CAPITAL ACCOUNTS					
52.00	General fund balance	148,624,681			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)	148,624,681	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	365,822,766	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet G-1

Date/Time Prepared:
2/28/2013 2:41 pm

	General Fund		Special Purpose Fund			
	1.00	2.00	3.00	4.00		
1.00 Fund balances at beginning of period		133,825,341		0		1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		25,732,393				2.00
3.00 Total (sum of line 1 and line 2)		159,557,734		0		3.00
4.00 CONTRIBUTIONS	2,464,329			0		4.00
5.00 CONTRIBUTIONS	60,036			0		5.00
6.00 NET REAL AND UNREAL GAINS	1,433,435			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)		3,957,800		0		10.00
11.00 Subtotal (line 3 plus line 10)		163,515,534		0		11.00
12.00 MINIMUM PENSION LIABILITY	12,769,907			0		12.00
13.00 NET REAL AND UNREAL GAINS	209,662			0		13.00
14.00 NET ASSETS RELEASED FROM RESTRICTION	1,902,428			0		14.00
15.00 OTHER	8,852			0		15.00
16.00 ROUNDING	4			0		16.00
17.00	0			0		17.00
18.00 Total deductions (sum of lines 12-17)		14,890,853		0		18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		148,624,681		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet G-1

Date/Time Prepared:
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		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	CONTRIBUTIONS	0		0		4.00
5.00	CONTRIBUTIONS	0		0		5.00
6.00	NET REAL AND UNREAL GAINS	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	MINIMUM PENSION LIABILITY	0		0		12.00
13.00	NET REAL AND UNREAL GAINS	0		0		13.00
14.00	NET ASSETS RELEASED FROM RESTRICTION	0		0		14.00
15.00	OTHER	0		0		15.00
16.00	ROUNDING	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: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	54,717,297		54,717,297	1.00
2.00	SUBPROVIDER - IPF	20,278,787		20,278,787	2.00
3.00	SUBPROVIDER - IRF	4,961,175		4,961,175	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	4,448,743		4,448,743	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)	84,406,002		84,406,002	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	30,195,051		30,195,051	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)	30,195,051		30,195,051	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	114,601,053		114,601,053	17.00
18.00	Ancillary services	242,109,393	382,380,388	624,489,781	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	806,633	806,633	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		5,171,511	5,171,511	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	3,593,326	3,593,326	26.00
27.00	NURSERY	2,840,499	0	2,840,499	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	359,550,945	391,951,858	751,502,803	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		269,625,493		29.00
30.00	PROVISION FOR BAD DEBTS	22,200,493			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)		22,200,493		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)		291,825,986		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet G-3

Date/Time Prepared:
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		1,00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	751,502,803	1.00
2.00	Less contractual allowances and discounts on patients' accounts	459,085,769	2.00
3.00	Net patient revenues (line 1 minus line 2)	292,417,034	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	291,825,986	4.00
5.00	Net income from service to patients (line 3 minus line 4)	591,048	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	7,796,981	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	414,022	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	1,466,636	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	89,918	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	2,902,774	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	911,150	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	9,415,122	24.00
24.01	TRANSFERS	1,842,928	24.01
24.02	TRANSFERS	301,814	24.02
25.00	Total other income (sum of lines 6-24)	25,141,345	25.00
26.00	Total (line 5 plus line 25)	25,732,393	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	25,732,393	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140015

Period:

Worksheet H

HHA CCN: 147031

From 10/01/2011

Date/Time Prepared:

To 09/30/2012

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		Salaries	Employee Benefits	Transportation (See Instructions)	Contracted/Purchased Services	Other Costs	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	1.00
2.00	Capital Related - Movable Equipment			0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	347,580	0	0	0	0	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,392,456	0	11,023	0	495,319	6.00
7.00	Physical Therapy	602,689	0	4,337	12,610	194,919	7.00
8.00	Occupational Therapy	181,973	0	1,379	0	61,992	8.00
9.00	Speech Pathology	18,533	0	181	0	8,154	9.00
10.00	Medical Social Services	102,736	0	14	0	614	10.00
11.00	Home Health Aide	175,770	0	2,577	0	115,829	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	4,928	0	0	0	118,483	22.00
23.00	All others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	2,826,665	0	19,511	12,610	995,310	24.00

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

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140015

Period: From 10/01/2011

Worksheet H

HHA CCN: 147031

To 09/30/2012

Date/Time Prepared: 2/28/2013 2:41 pm

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	Total (sum of cols. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
	6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	347,580	0	347,580	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	1,898,798	-1,155	1,897,643	0	6.00
7.00	Physical Therapy	814,555	0	814,555	0	7.00
8.00	Occupational Therapy	245,344	0	245,344	0	8.00
9.00	Speech Pathology	26,868	0	26,868	0	9.00
10.00	Medical Social Services	103,364	0	103,364	0	10.00
11.00	Home Health Aide	294,176	0	294,176	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	123,411	0	123,411	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	3,854,096	-1,155	3,852,941	0	24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2011
To 09/30/2012

Worksheet H-1
Part I
Date/Time Prepared:
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	Net Expenses For Cost Allocation (From wkst. H, col. 10)	Capital Related Costs			Transportation	
		Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance		
	0	1.00	2.00	3.00	4.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0		0	0	4.00
5.00	Administrative and General	347,580	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	1,897,643	0	0	0	6.00
7.00	Physical Therapy	814,555	0	0	0	7.00
8.00	Occupational Therapy	245,344	0	0	0	8.00
9.00	Speech Pathology	26,868	0	0	0	9.00
10.00	Medical Social Services	103,364	0	0	0	10.00
11.00	Home Health Aide	294,176	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	123,411	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	3,852,941	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet H-1
Part I
Date/Time Prepared:
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HHA CCN: 147031

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		Subtotal (cols. 0-4) 4A.00	Administrative & General 5.00	Total (cols. 4A + 5) 6.00	
GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0			1.00
2.00	Capital Related - Movable Equipment	0			2.00
3.00	Plant Operation & Maintenance	0			3.00
4.00	Transportation				4.00
5.00	Administrative and General	347,580	347,580		5.00
HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	1,897,643	188,163	2,085,806	6.00
7.00	Physical Therapy	814,555	80,769	895,324	7.00
8.00	Occupational Therapy	245,344	24,328	269,672	8.00
9.00	Speech Pathology	26,868	2,664	29,532	9.00
10.00	Medical Social Services	103,364	10,249	113,613	10.00
11.00	Home Health Aide	294,176	29,170	323,346	11.00
12.00	Supplies (see instructions)	0	0	0	12.00
13.00	Drugs	0	0	0	13.00
14.00	DME	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	17.00
18.00	Clinic	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	19.00
20.00	Day Care Program	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	21.00
22.00	Homemaker Service	123,411	12,237	135,648	22.00
23.00	All Others (specify)	0	0	0	23.00
24.00	Total (sum of lines 1-23)	3,852,941		3,852,941	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

worksheet H-1
Part II
Date/Time Prepared:
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HHA CCN: 147031

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		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)				
1.00	2.00	3.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0		-347,580	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-347,580	24.00
25.00	Cost To Be Allocated (per worksheet H-1, Part I)	0	0	0	0	0	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 140015

Period:

Worksheet H-1

HHA CCN: 147031

From 10/01/2011

Part II

To 09/30/2012

Date/Time Prepared:

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		Administrative & General (ACCUM. COST)	
		5.00	
GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures		1.00
2.00	Capital Related - Movable Equipment		2.00
3.00	Plant Operation & Maintenance		3.00
4.00	Transportation (see instructions)		4.00
5.00	Administrative and General	3,505,361	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	1,897,643	6.00
7.00	Physical Therapy	814,555	7.00
8.00	Occupational Therapy	245,344	8.00
9.00	Speech Pathology	26,868	9.00
10.00	Medical Social Services	103,364	10.00
11.00	Home Health Aide	294,176	11.00
12.00	Supplies (see instructions)	0	12.00
13.00	Drugs	0	13.00
14.00	DME	0	14.00
HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	15.00
16.00	Respiratory Therapy	0	16.00
17.00	Private Duty Nursing	0	17.00
18.00	Clinic	0	18.00
19.00	Health Promotion Activities	0	19.00
20.00	Day Care Program	0	20.00
21.00	Home Delivered Meals Program	0	21.00
22.00	Homemaker Service	123,411	22.00
23.00	All others (specify)	0	23.00
24.00	Total (sum of lines 1-23)	3,505,361	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	347,580	25.00
26.00	Unit Cost Multiplier	0.099157	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140015

Period: From 10/01/2011

Worksheet H-2

HHA CCN: 147031

To 09/30/2012

Part I

Date/Time Prepared: 2/28/2013 2:41 pm

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Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS				
		BLDG & FIXT	BUTLER-BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT	
	0	1.00	1.01	1.02	1.03	
1.00 Administrative and General	0	0	0	0	0	1.00
2.00 Skilled Nursing Care	2,085,806	0	0	0	0	2.00
3.00 Physical Therapy	895,324	0	0	0	0	3.00
4.00 Occupational Therapy	269,672	0	0	0	0	4.00
5.00 Speech Pathology	29,532	0	0	0	0	5.00
6.00 Medical Social Services	113,613	0	0	0	0	6.00
7.00 Home Health Aide	323,346	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	135,648	0	0	0	0	18.00
19.00 All others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	3,852,941	0	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140015

Period:

Worksheet H-2

HHA CCN: 147031

From 10/01/2011

Part I

To 09/30/2012

Date/Time Prepared:

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Agency I

PPS

Cost Center Description	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS	Subtotal	
	14TH STREET	MOB PHASE I	MVBLE EQUIP				
	1.04	1.05	2.00	4.00			
1.00 Administrative and General	15,161	0	21,496	90,613	127,270	1.00	
2.00 Skilled Nursing Care	0	0	0	363,006	2,448,812	2.00	
3.00 Physical Therapy	0	0	0	157,119	1,052,443	3.00	
4.00 Occupational Therapy	0	0	0	47,440	317,112	4.00	
5.00 Speech Pathology	0	0	0	4,831	34,363	5.00	
6.00 Medical Social Services	0	0	0	26,783	140,396	6.00	
7.00 Home Health Aide	0	0	0	45,823	369,169	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	1,285	136,933	18.00	
19.00 All Others (specify)	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19) (2)	15,161	0	21,496	736,900	4,626,498	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000	21.00	

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2011
To 09/30/2012

Worksheet H-2
Part I
Date/Time Prepared:
2/28/2013 2:41 pm

Home Health
Agency I

PPS

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
1.00	Administrative and General	35,416	82,961	0	135,699	0	1.00
2.00	Skilled Nursing Care	681,440	0	0	0	0	2.00
3.00	Physical Therapy	292,868	0	0	0	0	3.00
4.00	Occupational Therapy	88,244	0	0	0	0	4.00
5.00	Speech Pathology	9,562	0	0	0	0	5.00
6.00	Medical Social Services	39,069	0	0	0	0	6.00
7.00	Home Health Aide	102,730	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	38,105	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	1,287,434	82,961	0	135,699	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140015

Period:

Worksheet H-2

HHA CCN: 147031

From 10/01/2011

Part I

To 09/30/2012

Date/Time Prepared:

2/28/2013 2:41 pm

Home Health

Agency I

PPS

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL		
		11.00	13.00	16.00	20.00		
1.00	Administrative and General	104,477	590,078	0	0		1.00
2.00	Skilled Nursing Care	0	0	0	0		2.00
3.00	Physical Therapy	0	0	0	0		3.00
4.00	Occupational Therapy	0	0	0	0		4.00
5.00	Speech Pathology	0	0	0	0		5.00
6.00	Medical Social Services	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0	0		8.00
9.00	Drugs	0	0	0	0		9.00
10.00	DME	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0		13.00
14.00	Clinic	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0		18.00
19.00	All others (specify)	0	0	0	0		19.00
20.00	Total (sum of lines 1-19) (2)	104,477	590,078	0	0		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet H-2
Part I
Date/Time Prepared:
2/28/2013 2:41 pm

HHA CCN: 147031

Home Health
Agency I

PPS

Cost Center Description	INTERNS & RESIDENTS					
	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATOR Y	
	21.00	22.00	23.00	23.01	23.02	
1.00 Administrative and General	0	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	0	0	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet H-2
Part I
Date/Time Prepared:
2/28/2013 2:41 pm

HHA CCN: 147031

Home Health
Agency I

PPS

Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
	24.00	25.00	26.00	27.00	28.00	
1.00 Administrative and General	1,075,901	0	1,075,901			1.00
2.00 Skilled Nursing Care	3,130,252	0	3,130,252	585,584	3,715,836	2.00
3.00 Physical Therapy	1,345,311	0	1,345,311	251,671	1,596,982	3.00
4.00 Occupational Therapy	405,356	0	405,356	75,831	481,187	4.00
5.00 Speech Pathology	43,925	0	43,925	8,217	52,142	5.00
6.00 Medical Social Services	179,465	0	179,465	33,573	213,038	6.00
7.00 Home Health Aide	471,899	0	471,899	88,280	560,179	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	175,038	0	175,038	32,745	207,783	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	6,827,147	0	6,827,147	1,075,901	6,827,147	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.187073		21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140015

Period: From 10/01/2011

Worksheet H-2

HHA CCN: 147031

To 09/30/2012

Part II

Date/Time Prepared: 2/28/2013 2:41 pm

Home Health Agency I

PPS

Cost Center Description	CAPITAL RELATED COSTS					14TH STREET (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BUILDING FIXT (SQUARE FEET)	NEW BUILDING & FIXT (SQUARE FEET)			
	1.00	1.01	1.02	1.03	1.04		
1.00 Administrative and General	0	0	0	0	0	4,925	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	0	0	0	4,925	20.00
21.00 Total cost to be allocated	0	0	0	0	0	15,161	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	3.078376	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet H-2
Part II
Date/Time Prepared:
2/28/2013 2:41 pm

HHA CCN: 147031

Home Health
Agency I

PPS

Cost Center Description	CAPITAL RELATED COSTS			Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	MOB PHASE I (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)			
	1.05	2.00	4.00			
1.00 Administrative and General	0	21,054	347,580	0	127,270	1.00
2.00 Skilled Nursing Care	0	0	1,392,456	0	2,448,812	2.00
3.00 Physical Therapy	0	0	602,689	0	1,052,443	3.00
4.00 Occupational Therapy	0	0	181,973	0	317,112	4.00
5.00 Speech Pathology	0	0	18,533	0	34,363	5.00
6.00 Medical Social Services	0	0	102,736	0	140,396	6.00
7.00 Home Health Aide	0	0	175,770	0	369,169	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	4,928	0	136,933	18.00
19.00 All others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	21,054	2,826,665		4,626,498	20.00
21.00 Total cost to be allocated	0	21,496	736,900		1,287,434	21.00
22.00 Unit cost multiplier	0.000000	1.020994	0.260696		0.278274	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2011
To 09/30/2012

worksheet H-2
Part II
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		Home Health Agency I					PPS
		MAINTENANCE & REPAIRS (SQARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		6.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	4,925	0	3,683	0	13,396	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical social services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	4,925	0	3,683	0	13,396	20.00
21.00	Total cost to be allocated	82,961	0	135,699	0	104,477	21.00
22.00	Unit cost multiplier	16.844873	0.000000	36.844692	0.000000	7.799119	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2011
To 09/30/2012

Worksheet H-2
Part II
Date/Time Prepared:
2/28/2013 2:41 pm

Home Health
Agency I

PPS

Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOLS (ASSIGNED TIME)	INTERNS & RESIDENTS		
				SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	
				13.00	16.00	20.00
1.00 Administrative and General	90,416	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	90,416	0	0	0	0	20.00
21.00 Total cost to be allocated	590,078	0	0	0	0	21.00
22.00 Unit cost multiplier	6.526256	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2011
To 09/30/2012

Worksheet H-2
Part II
Date/Time Prepared:
2/28/2013 2:41 pm

Home Health Agency I PPS

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)		
		23.00	23.01	23.02		
1.00	Administrative and General	0	0	0		1.00
2.00	Skilled Nursing Care	0	0	0		2.00
3.00	Physical Therapy	0	0	0		3.00
4.00	Occupational Therapy	0	0	0		4.00
5.00	Speech Pathology	0	0	0		5.00
6.00	Medical Social Services	0	0	0		6.00
7.00	Home Health Aide	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0		8.00
9.00	Drugs	0	0	0		9.00
10.00	DME	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0		13.00
14.00	Clinic	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0		15.00
16.00	Day Care Program	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0		17.00
18.00	Homemaker Service	0	0	0		18.00
19.00	All others (specify)	0	0	0		19.00
20.00	Total (sum of lines 1-19)	0	0	0		20.00
21.00	Total cost to be allocated	0	0	0		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2011
To 09/30/2012

Worksheet H-3
Parts I-II
Date/Time Prepared:
2/28/2013 2:41 pm

Title XVIII		Home Health Agency I		PPS	
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits
	0	1.00	2.00	3.00	4.00

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

Cost Per Visit Computation

1.00	Skilled Nursing Care	2.00	3,715,836		3,715,836	22,658	1.00
2.00	Physical Therapy	3.00	1,596,982	0	1,596,982	8,914	2.00
3.00	Occupational Therapy	4.00	481,187	0	481,187	2,835	3.00
4.00	Speech Pathology	5.00	52,142	0	52,142	373	4.00
5.00	Medical Social Services	6.00	213,038		213,038	27	5.00
6.00	Home Health Aide	7.00	560,179		560,179	5,300	6.00
7.00	Total (sum of lines 1-6)		6,619,364	0	6,619,364	40,107	7.00

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

Limitation Cost Computation

8.00	Skilled Nursing Care	99914	7,024	6,977	8.00
8.01	Skilled Nursing Care	99926	590	350	8.01
9.00	Physical Therapy	99914	3,873	2,205	9.00
9.01	Physical Therapy	99926	184	107	9.01
10.00	Occupational Therapy	99914	1,236	643	10.00
10.01	Occupational Therapy	99926	68	44	10.01
11.00	Speech Pathology	99914	141	80	11.00
11.01	Speech Pathology	99926	10	17	11.01
12.00	Medical Social Services	99914	7	8	12.00
12.01	Medical Social Services	99926	0	0	12.01
13.00	Home Health Aide	99914	893	2,835	13.00
13.01	Home Health Aide	99926	186	353	13.01
14.00	Total (sum of lines 8-13)		14,212	13,619	14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)
	0	1.00	2.00	3.00	4.00

Supplies and Drugs Cost Computations

15.00	Cost of Medical Supplies	8.00	0	8,993	44,937	15.00
16.00	Cost of Drugs	9.00	0	0	0	16.00

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

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

1.00	Physical Therapy	66.00	0.514496	0	0	1.00
2.00	Occupational Therapy	67.00	0.314541	0	0	2.00
3.00	Speech Pathology	68.00	0.277298	0	0	3.00
4.00	Cost of Medical Supplies	71.00	0.200116	44,937	8,993	4.00
5.00	Cost of Drugs	73.00	0.214416	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140015

Period: From 10/01/2011

Worksheet H-3

HHA CCN: 147031

To 09/30/2012

Parts I-II

Date/Time Prepared: 2/28/2013 2:41 pm

Title XVIII

Home Health Agency I

PPS

Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Program Visits			
		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	5.00	6.00	7.00	8.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION					
Cost Per Visit Computation					
1.00 Skilled Nursing Care	164.00	7,614	7,327		1.00
2.00 Physical Therapy	179.15	4,057	2,312		2.00
3.00 Occupational Therapy	169.73	1,304	687		3.00
4.00 Speech Pathology	139.79	151	97		4.00
5.00 Medical Social Services	7,890.30	7	8		5.00
6.00 Home Health Aide	105.69	1,079	3,188		6.00
7.00 Total (sum of lines 1-6)		14,212	13,619		7.00
Cost Center Description					
	5.00	6.00	7.00	8.00	9.00
Limitation Cost Computation					
8.00 Skilled Nursing Care					8.00
8.01 Skilled Nursing Care					8.01
9.00 Physical Therapy					9.00
9.01 Physical Therapy					9.01
10.00 Occupational Therapy					10.00
10.01 Occupational Therapy					10.01
11.00 Speech Pathology					11.00
11.01 Speech Pathology					11.01
12.00 Medical Social Services					12.00
12.01 Medical Social Services					12.01
13.00 Home Health Aide					13.00
13.01 Home Health Aide					13.01
14.00 Total (sum of lines 8-13)					14.00
Program Covered Charges					
Cost Center Description	Ratio (col. 3 ÷ col. 4)	Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		5.00	6.00	7.00	
Supplies and Drugs Cost Computations					
15.00 Cost of Medical Supplies	0.200125				15.00
16.00 Cost of Drugs	0.000000		0	0	16.00
Cost Center Description					
			Transfer to Part I as indicated		
			4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS					
1.00 Physical Therapy		col. 2, line 2.00			1.00
2.00 Occupational Therapy		col. 2, line 3.00			2.00
3.00 Speech Pathology		col. 2, line 4.00			3.00
4.00 Cost of Medical Supplies		col. 2, line 15.00			4.00
5.00 Cost of Drugs		col. 2, line 16.00			5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140015

Period: From 10/01/2011

Worksheet H-3

HHA CCN: 147031

To 09/30/2012

Parts I-II

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Title XVIII

Home Health Agency I

PPS

Cost Center Description	Cost of Services			Total Program Cost (sum of cols. 9-10)	
	Part A	Part B			
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	9.00	10.00	11.00	12.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION					
Cost Per Visit Computation					
1.00	Skilled Nursing Care	1,248,696	1,201,628	2,450,324	1.00
2.00	Physical Therapy	726,812	414,195	1,141,007	2.00
3.00	Occupational Therapy	221,328	116,605	337,933	3.00
4.00	Speech Pathology	21,108	13,560	34,668	4.00
5.00	Medical Social Services	55,232	63,122	118,354	5.00
6.00	Home Health Aide	114,040	336,940	450,980	6.00
7.00	Total (sum of lines 1-6)	2,387,216	2,146,050	4,533,266	7.00
Cost Center Description					
		10.00	11.00	12.00	
Limitation Cost Computation					
8.00	Skilled Nursing Care				8.00
8.01	Skilled Nursing Care				8.01
9.00	Physical Therapy				9.00
9.01	Physical Therapy				9.01
10.00	Occupational Therapy				10.00
10.01	Occupational Therapy				10.01
11.00	Speech Pathology				11.00
11.01	Speech Pathology				11.01
12.00	Medical Social Services				12.00
12.01	Medical Social Services				12.01
13.00	Home Health Aide				13.00
13.01	Home Health Aide				13.01
14.00	Total (sum of lines 8-13)				14.00
Cost of Services					
Cost Center Description	Part A	Part B			
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	9.00	10.00	11.00		
Supplies and Drugs Cost Computations					
15.00	Cost of Medical Supplies				15.00
16.00	Cost of Drugs		0	0	16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140015

Period:

Worksheet H-4

HHA CCN: 147031

From 10/01/2011

Part I-II

To 09/30/2012

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Home Health Agency I

PPS

	Part A	Part B		
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	1.00	2.00	3.00	

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

Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	2,039,052	3,858,739	0	2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	2,039,052	3,858,739	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	2,039,052	3,858,739	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00
			Part A Services	Part B Services	
			1.00	2.00	

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	2,138,512	1,372,985	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	37,802	142,327	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	21,979	23,178	13.00
14.00	Total PPS Reimbursement - PEP Episodes	15,448	7,004	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	8,961	50,034	15.00
16.00	Total PPS outlier reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)	0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	2,222,702	1,595,528	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,222,702	1,595,528	24.00
25.00	Coinsurance billed to program patients (from your records)	0	0	25.00
26.00	Net cost (line 24 minus line 25)	2,222,702	1,595,528	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	2,222,702	1,595,528	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	2,222,702	1,595,528	31.00
32.00	Interim payments (see instructions)	2,222,702	1,595,528	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	35.00

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

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2011
To 09/30/2012

Worksheet H-5
Date/Time Prepared:
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Home Health
Agency I

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,222,702		1,595,528	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		2,222,702		1,595,528	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,222,702		1,595,528	7.00
				Contractor Number	Date (Mo/Day/Yr)	
				1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140015

Period: From 10/01/2011

Worksheet K

Hospice CCN: 141501

To 09/30/2012

Date/Time Prepared: 2/28/2013 2:41 pm

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	382,726	0	100,827	0	167,597	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	28,596	0	0	47,500	0	9.00
10.00	Nursing Care	918,131	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	64	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	187,602	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	84,917	0	0	79,106	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	135,202	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	42,931	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)	1,602,036	0	100,827	126,606	345,730	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140015

Period:

Worksheet K

Hospice CCN: 141501

From 10/01/2011

Date/Time Prepared:

To 09/30/2012

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		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	651,150	0	651,150	0	651,150	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	76,096	0	76,096	-29,065	47,031	9.00
10.00	Nursing Care	918,131	0	918,131	0	918,131	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	64	0	64	0	64	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	187,602	0	187,602	0	187,602	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	164,023	0	164,023	0	164,023	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	135,202	0	135,202	0	135,202	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	42,931	-30	42,901	0	42,901	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)	2,175,199	-30	2,175,169	-29,065	2,146,104	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140015

Period:

Worksheet K-1

Hospice CCN: 141501

From 10/01/2011

To 09/30/2012

Date/Time Prepared:
2/28/2013 2:41 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	918,131	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	187,602	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	187,602	0	918,131	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2011
To 09/30/2012

Worksheet K-1
Date/Time Prepared:
2/28/2013 2:41 pm

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	382,726	382,726	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	28,596	28,596	9.00
10.00	Nursing Care		0	0	918,131	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	64	0	0	64	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	187,602	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		84,917	0	84,917	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)	64	84,917	411,322	1,602,036	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES

Provider CCN: 140015

Period:

Worksheet K-3

Hospice CCN: 141501

From 10/01/2011

Date/Time Prepared:

To 09/30/2012

2/28/2013 2:41 pm

Hospice I

	Administrator	Director	Social Services	Supervisors	Nurses	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						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
INPATIENT CARE SERVICE						
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
VISITING SERVICES						
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	0	12.00
13.00	0	0	0	0	0	13.00
14.00	0	0	0	0	0	14.00
15.00	0	0	0	0	0	15.00
16.00	0	0	0	0	0	16.00
17.00	0	0	0	0	0	17.00
18.00	0	0	0	0	0	18.00
19.00	0	0	0	0	0	19.00
20.00	0	0	0	0	0	20.00
21.00	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00						22.00
23.00						23.00
24.00						24.00
25.00						25.00
26.00						26.00
27.00	0	0	0	0	0	27.00
28.00	0	0	0	0	0	28.00
29.00	0	0	0	0	0	29.00
30.00	0	0	0	0	0	30.00
31.00	0	0	0	0	0	31.00
32.00	0	0	0	0	0	32.00
33.00	0	0	0	0	0	33.00
34.00	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	0	0	0	0	0	35.00
36.00	0	0	0	0	0	36.00
37.00	0	0	0	0	0	37.00
38.00	0	0	0	0	0	38.00
39.00	0	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES

Provider CCN: 140015

Period:

Worksheet K-3

Hospice CCN: 141501

From 10/01/2011
To 09/30/2012

Date/Time Prepared:
2/28/2013 2:41 pm

Hospice I

	Total Therapists	Aides	All-Other	Total (1)	
	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS					
1.00					1.00
2.00					2.00
3.00		0	0	0	3.00
4.00		0	0	0	4.00
5.00		0	0	0	5.00
6.00		0	0	0	6.00
INPATIENT CARE SERVICE					
7.00		0	0	0	7.00
8.00		0	0	0	8.00
VISITING SERVICES					
9.00		0	47,500	47,500	9.00
10.00		0	0	0	10.00
11.00		0	0	0	11.00
12.00	0	0	0	0	12.00
13.00	0	0	0	0	13.00
14.00	0	0	0	0	14.00
15.00		0	0	0	15.00
16.00		0	0	0	16.00
17.00		0	0	0	17.00
18.00		0	0	0	18.00
19.00		79,106	0	79,106	19.00
20.00		0	0	0	20.00
21.00		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS					
22.00					22.00
23.00					23.00
24.00					24.00
25.00					25.00
26.00					26.00
27.00		0	0	0	27.00
28.00		0	0	0	28.00
29.00		0	0	0	29.00
30.00		0	0	0	30.00
31.00		0	0	0	31.00
32.00		0	0	0	32.00
33.00		0	0	0	33.00
34.00		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE					
35.00		0	0	0	35.00
36.00		0	0	0	36.00
37.00		0	0	0	37.00
38.00		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	79,106	47,500	126,606

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet K-4
Part I
Date/Time Prepared:
2/28/2013 2:41 pm

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
		0	1.00	2.00	3.00	4.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	651,150	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	47,031	0	0	0	0	9.00
10.00	Nursing Care	918,131	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	64	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	187,602	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	164,023	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	135,202	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	42,901	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)	2,146,104	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2011
To 09/30/2012

Worksheet K-4
Part I
Date/Time Prepared:
2/28/2013 2:41 pm

Hospice I

	VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A + col. 6)	
	5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.				1.00
2.00	Capital Related Costs-Movable Equip.				2.00
3.00	Plant Operation and Maintenance				3.00
4.00	Transportation - Staff				4.00
5.00	Volunteer Service Coordination	0			5.00
6.00	Administrative and General	0	651,150	651,150	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	47,031	20,485	67,516
10.00	Nursing Care	0	918,131	399,906	1,318,037
11.00	Nursing Care-Continuous Home Care	0	0	0	0
12.00	Physical Therapy	0	64	28	92
13.00	Occupational Therapy	0	0	0	0
14.00	Speech/ Language Pathology	0	0	0	0
15.00	Medical Social Services	0	187,602	81,713	269,315
16.00	Spiritual Counseling	0	0	0	0
17.00	Dietary Counseling	0	0	0	0
18.00	Counseling - Other	0	0	0	0
19.00	Home Health Aide and Homemaker	0	164,023	71,443	235,466
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0
21.00	Other	0	0	0	0
OTHER HOSPICE SERVICE COSTS					
22.00	Drugs, Biological and Infusion Therapy	0	135,202	58,889	194,091
23.00	Analgesics	0	0	0	0
24.00	Sedatives / Hypnotics	0	0	0	0
25.00	Other - Specify	0	0	0	0
26.00	Durable Medical Equipment/Oxygen	0	0	0	0
27.00	Patient Transportation	0	0	0	0
28.00	Imaging Services	0	0	0	0
29.00	Labs and Diagnostics	0	0	0	0
30.00	Medical Supplies	0	42,901	18,686	61,587
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0
32.00	Radiation Therapy	0	0	0	0
33.00	Chemotherapy	0	0	0	0
34.00	Other	0	0	0	0
HOSPICE NONREIMBURSABLE SERVICE					
35.00	Bereavement Program Costs	0	0	0	0
36.00	Volunteer Program Costs	0	0	0	0
37.00	Fundraising	0	0	0	0
38.00	Other Program Costs	0	0	0	0
39.00	Total (sum of lines 1 thru 38)	0	2,146,104		2,146,104

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:

Worksheet K-4

Hospice CCN: 141501

From 10/01/2011

Part II

To 09/30/2012

Date/Time Prepared:

2/28/2013 2:41 pm

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:

Worksheet K-4

Hospice CCN: 141501

From 10/01/2011

Part II

To 09/30/2012

Date/Time Prepared:

Hospice I

2/28/2013 2:41 pm

		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	-651,150	1,494,954	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	47,031	9.00
10.00	Nursing Care	0	918,131	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	64	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	187,602	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	164,023	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	135,202	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	42,901	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)		651,150	39.00
40.00	Unit Cost Multiplier		0.435565	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015

Period:

Worksheet K-5

Hospice CCN: 141501

From 10/01/2011

Part I

To 09/30/2012

Date/Time Prepared:

2/28/2013 2:41 pm

Cost Center Description		Hospice I					35.00
		Hospice Trial Balance (1)	CAPITAL RELATED COSTS			NEW BUILDING & FIXT	
			BIDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT		
		0	1.00	1.01	1.02	1.03	
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	67,516	0	0	0	0	4.00
5.00	Nursing Care	1,318,037	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	92	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	269,315	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	235,466	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	194,091	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	61,587	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)	2,146,104	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: 140015

Period:

Worksheet K-5

Hospice CCN: 141501

From 10/01/2011

Part I

To 09/30/2012

Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description	CAPITAL RELATED COSTS			Hospice I		Subtotal	
	14TH STREET	MOB PHASE I	MVBLE EQUIP	EMPLOYEE BENEFITS	4A		
	1.04	1.05	2.00				
				4.00			
1.00 Administrative and General	22,867	0	9,711	99,653	132,231	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	67,516	4.00	
5.00 Nursing Care	0	0	0	239,352	1,557,389	5.00	
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00	
7.00 Physical Therapy	0	0	0	17	109	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	48,907	318,222	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	22,138	257,604	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	194,091	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	61,587	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)	22,867	0	9,711	410,067	2,588,749	34.00	
35.00 Unit Cost Multiplier (see instructions)					0.000000	35.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015

Period:

Worksheet K-5

Hospice CCN: 141501

From 10/01/2011

Part I

To 09/30/2012

Date/Time Prepared:

2/28/2013 2:41 pm

Cost Center Description		Hospice I					
		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
1.00	Administrative and General	36,796	125,123	2,509	23,875	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	18,788	0	0	0	0	4.00
5.00	Nursing Care	433,383	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	30	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	88,553	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	71,684	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	54,010	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	17,138	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)	720,382	125,123	2,509	23,875	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015

Period:

Worksheet K-5

Hospice CCN: 141501

From 10/01/2011

Part I

To 09/30/2012

Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description	Hospice I					
	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL		
	11.00	13.00	16.00	20.00		
1.00 Administrative and General	76,049	429,512	0	16,292		1.00
2.00 Inpatient - General Care	0	0	0	0		2.00
3.00 Inpatient - Respite Care	0	0	0	0		3.00
4.00 Physician Services	0	0	0	0		4.00
5.00 Nursing Care	0	0	0	0		5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00 Physical Therapy	0	0	0	0		7.00
8.00 Occupational Therapy	0	0	0	0		8.00
9.00 Speech/ Language Pathology	0	0	0	0		9.00
10.00 Medical Social Services	0	0	0	0		10.00
11.00 Spiritual Counseling	0	0	0	0		11.00
12.00 Dietary Counseling	0	0	0	0		12.00
13.00 Counseling - other	0	0	0	0		13.00
14.00 Home Health Aide and Homemaker	0	0	0	0		14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00 Other	0	0	0	0		16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00 Analgesics	0	0	0	0		18.00
19.00 Sedatives / Hypnotics	0	0	0	0		19.00
20.00 Other - Specify	0	0	0	0		20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00 Patient Transportation	0	0	0	0		22.00
23.00 Imaging Services	0	0	0	0		23.00
24.00 Labs and Diagnostics	0	0	0	0		24.00
25.00 Medical Supplies	0	0	0	0		25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00 Radiation Therapy	0	0	0	0		27.00
28.00 Chemotherapy	0	0	0	0		28.00
29.00 Other	0	0	0	0		29.00
30.00 Bereavement Program Costs	0	0	0	0		30.00
31.00 Volunteer Program Costs	0	0	0	0		31.00
32.00 Fundraising	0	0	0	0		32.00
33.00 Other Program Costs	0	0	0	0		33.00
34.00 Total (sum of lines 1 thru 33) (2)	76,049	429,512	0	16,292		34.00
35.00 Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2011
To 09/30/2012

Worksheet K-5
Part I
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		Hospice I					
		INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
		SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
		21.00	22.00	23.00	23.01	23.02	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet K-5
Part I
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 + 25)	Hospice I	
					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	842,387				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	86,304	0	86,304	23,153	4.00
5.00	Nursing Care	1,990,772	0	1,990,772	534,060	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	6.00
7.00	Physical Therapy	139	0	139	37	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	406,775	0	406,775	109,124	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	329,288	0	329,288	88,337	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	248,101	0	248,101	66,557	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	78,725	0	78,725	21,119	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)	3,982,491	0	3,982,491		34.00
35.00	Unit Cost Multiplier (see instructions)				0.268267	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2011
To 09/30/2012

Worksheet K-5
Part II
Date/Time Prepared:
2/28/2013 2:41 pm

Hospice I

Cost Center Description	CAPITAL RELATED COSTS					
	BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BUILDING & FIXT (SQUARE FEET)	NEW BUILDING & FIXT (SQUARE FEET)	14TH STREET (SQUARE FEET)	
	1.00	1.01	1.02	1.03	1.04	
1.00 Administrative and General	0	0	0	0	7,428	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	7,428	34.00
35.00 Total cost to be allocated	0	0	0	0	22,867	35.00
36.00 Unit cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000	3.078487	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2011
To 09/30/2012

Worksheet K-5
Part II
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	MOB PHASE I (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.05	2.00	4.00				
1.00 Administrative and General	0	9,512	382,257	0	0	132,231	1.00
2.00 Inpatient - General Care	0	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	67,516	4.00
5.00 Nursing Care	0	0	918,131	0	0	1,557,389	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	64	0	0	109	7.00
8.00 Occupational Therapy	0	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	187,602	0	0	318,222	10.00
11.00 Spiritual Counseling	0	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	84,917	0	0	257,604	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	194,091	17.00
18.00 Analgesics	0	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	61,587	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	9,512	1,572,971			2,588,749	34.00
35.00 Total cost to be allocated	0	9,711	410,067			720,382	35.00
36.00 Unit Cost Multiplier (see instructions)	0.000000	1.020921	0.260696			0.278274	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2011
To 09/30/2012

Worksheet K-5
Part II
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description	Hospice I					
	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
	6.00	8.00	9.00	10.00	11.00	
1.00 Administrative and General	7,428	2,800	648	0	9,751	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)	7,428	2,800	648	0	9,751	34.00
35.00 Total cost to be allocated	125,123	2,509	23,875	0	76,049	35.00
36.00 Unit cost Multiplier (see instructions)	16.844777	0.896071	36.844136	0.000000	7.799098	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015

Period: From 10/01/2011

Worksheet K-5

Hospice CCN: 141501

To 09/30/2012

Part II

Date/Time Prepared:
2/28/2013 2:41 pm

Hospice I

Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		
				SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	
				13.00	16.00	
1.00 Administrative and General	65,813	0	94	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)	65,813	0	94	0	0	34.00
35.00 Total cost to be allocated	429,512	0	16,292	0	0	35.00
36.00 Unit Cost Multiplier (see instructions)	6.526249	0.000000	173.319149	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet K-5
Part II
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		PARAMED ED	PARAMED ED	PARAMED ED	Hospice I
		PRGM (ASSIGNED TIME)	PRGM-RADIOLOGY (ASSIGNED TIME)	PRGM-LABORATOR Y (ASSIGNED TIME)	
		23.00	23.01	23.02	
1.00	Administrative and General	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	3.00
4.00	Physician Services	0	0	0	4.00
5.00	Nursing Care	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	6.00
7.00	Physical Therapy	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	9.00
10.00	Medical Social Services	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	12.00
13.00	Counseling - Other	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	15.00
16.00	Other	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	17.00
18.00	Analgesics	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	19.00
20.00	Other - Specify	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	21.00
22.00	Patient Transportation	0	0	0	22.00
23.00	Imaging Services	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	24.00
25.00	Medical Supplies	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	27.00
28.00	Chemotherapy	0	0	0	28.00
29.00	Other	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	31.00
32.00	Fundraising	0	0	0	32.00
33.00	Other Program Costs	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	34.00
35.00	Total cost to be allocated	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet K-5
Part III
Date/Time Prepared:
2/28/2013 2:41 pm

Cost Center Description		Hospice I			
		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	0.514496	0	0 1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.314541	0	0 2.00
3.00	SPEECH PATHOLOGY	68.00	0.277298	0	0 3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.214416	0	0 4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00			5.00
6.00	LABORATORY	60.00	0.129525	0	0 6.00
6.01	BLOOD LABORATORY	60.01			6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.200116	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	OTHER ANCILLARY SERVICE COST CENTERS	76.00			10.00
11.00	Totals (sum of lines 1-10)				0 11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 140015

Period:

Worksheet K-6

Hospice CCN: 141501

From 10/01/2011
To 09/30/2012

Date/Time Prepared:
2/28/2013 2:41 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				3,982,491	1.00
2.00	Total Unduplicated Days (worksheet S-9, column 6, line 5)				16,895	2.00
3.00	Average cost per diem (line 1 divided by line 2)				235.72	3.00
4.00	Upduplicated Medicare Days (worksheet S-9, column 1, line 5)	16,021				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	3,776,470				5.00
6.00	Unduplicated Medicaid Days (worksheet S-9, column 2, line 5)		256			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		60,344			7.00
8.00	Upduplicated SNF Days (worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (worksheet S-9, column 4, line 5)		119			10.00
11.00	Aggregate NF cost (line 3 times line 10)		28,051			11.00
12.00	Other Unduplicated days (worksheet S-9, column 5, line 5)			618		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			145,675		13.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet L
Parts I-III
Date/Time Prepared:
2/28/2013 2:41 pm

		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		3,033,287	1.00
2.00	Capital DRG outlier payments		160,598	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		106.27	3.00
4.00	Number of interns & residents (see instructions)		14.77	4.00
5.00	Indirect medical education percentage (see instructions)		4.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		121,331	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)		3,315,216	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

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

Provider CCN: 140015
Component CCN: 143422

Period:
From 10/01/2011
To 09/30/2012

Worksheet M-1
Date/Time Prepared:
2/28/2013 2:41 pm

		Rural Health Clinic (RHC) I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	2.00
3.00	Nurse Practitioner	106,690	0	106,690	0	3.00
4.00	Visiting Nurse	0	0	0	0	4.00
5.00	Other Nurse	155,172	0	155,172	0	5.00
6.00	Clinical Psychologist	0	0	0	0	6.00
7.00	Clinical Social worker	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	261,862	0	261,862	0	10.00
11.00	Physician Services Under Agreement	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	281,832	281,832	0	12.00
13.00	Other Costs Under Agreement	0	644	644	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	282,476	282,476	0	14.00
15.00	Medical Supplies	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	18.00
19.00	Other Health Care Costs	0	41,172	41,172	-2,293	19.00
20.00	Allowable GME Costs	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	41,172	41,172	-2,293	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	261,862	323,648	585,510	-2,293	22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	23.00
24.00	Dental	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	13,200	13,200	0	29.00
30.00	Administrative Costs	96,537	94,432	190,969	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	96,537	107,632	204,169	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	358,399	431,280	789,679	-2,293	32.00

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

Provider CCN: 140015

Period:
From 10/01/2011
To 09/30/2012

Worksheet M-1

Component CCN: 143422

Date/Time Prepared:
2/28/2013 2:41 pm

Rural Health
Clinic (RHC) I

Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	1.00
2.00	Physician Assistant	0	2.00
3.00	Nurse Practitioner	0	3.00
4.00	Visiting Nurse	106,690	4.00
5.00	Other Nurse	0	5.00
6.00	Clinical Psychologist	155,172	6.00
7.00	Clinical Social Worker	0	7.00
8.00	Laboratory Technician	0	8.00
9.00	Other Facility Health Care Staff Costs	0	9.00
10.00	Subtotal (sum of lines 1-9)	0	10.00
11.00	Physician Services Under Agreement	261,862	11.00
12.00	Physician Supervision Under Agreement	0	12.00
13.00	Other Costs Under Agreement	281,832	13.00
14.00	Subtotal (sum of lines 11-13)	644	14.00
15.00	Medical Supplies	282,476	15.00
16.00	Transportation (Health Care Staff)	0	16.00
17.00	Depreciation-Medical Equipment	0	17.00
18.00	Professional Liability Insurance	0	18.00
19.00	Other Health Care Costs	0	19.00
20.00	Allowable GME Costs	38,879	20.00
21.00	Subtotal (sum of lines 15-20)	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	38,879	22.00
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	23.00
24.00	Dental	0	24.00
25.00	Optometry	0	25.00
26.00	All other nonreimbursable costs	0	26.00
27.00	Nonallowable GME costs	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	28.00
FACILITY OVERHEAD			
29.00	Facility Costs	-38,835	29.00
30.00	Administrative Costs	-25,635	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	190,969	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-38,835	32.00
		165,334	
		748,551	

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140015

Period:

Worksheet M-2

Component CCN: 143422

From 10/01/2011
To 09/30/2012

Date/Time Prepared:
2/28/2013 2:41 pm

Rural Health
Clinic (RHC) I

Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	5.00
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.00	5,036	4,200	4,200	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.87	2,699	2,100	1,827	3.00
4.00	Subtotal (sum of lines 1-3)	1.87	7,735		6,027	7,735
5.00	Visiting Nurse	0.00	0			0
6.00	Clinical psychologist	0.00	0			0
7.00	Clinical social worker	0.00	0			0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0
8.00	Total FTEs and Visits (sum of lines 4-7)	1.87	7,735			7,735
9.00	Physician Services Under Agreements		0			0
						1.00

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					583,217	10.00
11.00	Total nonreimbursable costs (from worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					583,217	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					165,334	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					328,398	15.00
16.00	Total overhead (sum of lines 14 and 15)					493,732	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					493,732	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					493,732	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,076,949	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 140015

Period: From 10/01/2011

Worksheet M-3

Component CCN: 143422

To 09/30/2012

Date/Time Prepared: 2/28/2013 2:41 pm

Title XVIII

Rural Health Clinic (RHC) I

Cost

		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from worksheet M-2, line 20)		1,076,949	1.00
2.00	Cost of vaccines and their administration (from worksheet M-4, line 15)		10,279	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,066,670	3.00
4.00	Total visits (from worksheet M-2, column 5, line 8)		7,735	4.00
5.00	Physicians visits under agreement (from worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		7,735	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		137.90	7.00
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	78.07	78.54	8.00
9.00	Rate for Program covered visits (see instructions)	78.07	78.54	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	624	1,986	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	48,716	155,980	11.00
12.00	Program covered visits for mental health services (from contractor records)	14	41	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	1,093	3,220	13.00
14.00	Limit adjustment for mental health services (see instructions)	751	2,415	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		207,862	16.00
16.01	Total program charges (see instructions)(from contractor's records)		410,775	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		780	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		395	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		136,794	16.04
16.05	Total program cost (see instructions)		137,189	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: beneficiary deductible for RHC only (see instructions) (from contractor records)		36,475	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		76,180	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		137,189	20.00
21.00	Program cost of vaccines and their administration (from wkst. M-4, line 16)		5,290	21.00
22.00	Total reimbursable program cost (line 20 plus line 21)		142,479	22.00
23.00	Reimbursable bad debts (see instructions)		182	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		142,661	26.00
27.00	Interim payments		137,998	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		4,663	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 140015
Component CCN: 143422

Period:
From 10/01/2011
To 09/30/2012

Worksheet M-4

Date/Time Prepared:
2/28/2013 2:41 pm

		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from worksheet M-1, column 7, line 10)	261,862	261,862	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000262	0.002887	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	69	756	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,610	3,132	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,679	3,888	5.00
6.00	Total direct cost of the facility (from worksheet M-1, column 7, line 22)	583,217	583,217	6.00
7.00	Total overhead (from worksheet M-2, line 16)	493,732	493,732	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002879	0.006666	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,421	3,291	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,100	7,179	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	26	286	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	119.23	25.10	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	17	130	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,027	3,263	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to worksheet M-3, line 2)		10,279	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to worksheet M-3, line 21)		5,290	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 140015
Component CCN: 143422

Period:
From 10/01/2011
To 09/30/2012

Worksheet M-5
Date/Time Prepared:
2/28/2013 2:41 pm

Rural Health
Clinic (RHC) I

Cost

		Part B		
		mm/dd/yyyy	Amount	
1.00	Total interim payments paid to provider	1.00	2.00	
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		134,345	1.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		0	2.00
Program to Provider				
3.01		09/25/2012	3,653	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		3,653	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		137,998	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		4,663	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		142,661	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00