

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: 140110	Period: From 05/01/2012 To 09/30/2012
		Worksheet S Parts I-III Date/Time Prepared: 2/28/2013 12:49 pm

PART I - COST REPORT STATUS		
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 2/28/2013 Time: 12:49 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above 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 OTTAWA REGIONAL HOSPITAL & HEALTHCARE (140110) for the cost reporting period beginning 05/01/2012 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.

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

_____ Title

_____ Date

Cost Center Description	Title XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-211,566	-467,995	0	0	1.00
2.00 Subprovider - IPF	0	1,330	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	-210,236	-467,994	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140110		Period: From 05/01/2012 To 09/30/2012		Worksheet S-2 Part I Date/Time Prepared: 2/28/2013 12:42 pm						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1100 EAST NORRIS DRIVE			PO Box:						1.00		
2.00	City: OTTAWA			State: IL		Zip Code: 61350		County: LASALLE		2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
								V	XVIII	XIX		
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		OTTAWA REGIONAL HOSPITAL & HEALTHCARE		140110	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF		OTTAWA REGIONAL PSYCHIATRIC UNIT		14S110	16974	4	05/01/1984	N	P	O	4.00
5.00	Subprovider - IRF											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											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA		OTTAWA VISITING NURSING SERVICE		147048	16974		11/01/1985	N	P	N	12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice		HOSPICE OF COMMUNITY HOSPITAL		141570	16974		02/01/1984				14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) 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)						05/01/2012		09/30/2012		20.00	
21.00	Type of Control (see instructions)								2		21.00	
Inpatient PPS Information												
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y		N		22.00	
23.00	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.						1		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 days	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.			312	281	0	0	5	0		24.00	
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.			0	0	0	0	0	0		25.00	
							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	
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	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.								0		35.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/28/2013 12:42 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	1				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.	05/01/2012	09/30/2012			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.	Y	Y			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.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	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: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet S-2
Part I
Date/Time Prepared:
2/28/2013 12:42 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	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 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

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		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.	N				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		76.00
		1.00				
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes 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		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					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		
		1.00		2.00		
		Speech		Respiratory		
		3.00		4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
		1.00		2.00		3.00
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.	2				118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	64,609	0	0	
			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.		N		
119.00	DO NOT USE THIS LINE				
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.		N	Y	
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		
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		
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.				
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.				
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.				
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.				
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.				
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.				
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.				
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.				
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.				
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	149006	
		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: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS		Contractor's Number: 00131	
142.00	Street: 800 N.E. GLEN OAK AVENUE	PO Box:			
143.00	City: PEORIA	State: IL		Zip Code: 61603	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y		
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.		N		
			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		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		
		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
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140110			Period: From 05/01/2012 To 09/30/2012		Worksheet S-2 Part I Date/Time Prepared: 2/28/2013 12:42 pm	
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet S-2 Part II Date/Time Prepared: 2/28/2013 12:42 pm
		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	Y	04/30/2012	1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	07/31/2012
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	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.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		N	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	01/23/2013	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.	Y		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet S-2 Part II Date/Time Prepared: 2/28/2013 12:42 pm
		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 relieved for Medicare purposes? If yes, see instructions			22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00
		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.	DAWN	TROMPETER	41.00
42.00	Enter the employer/company name of the cost report preparer.	OSF SAINT ELIZABETH MEDICAL CENTER		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-431-5458	DAWN.C.TROMPETER@OSFHEALTHCARE.ORG	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	01/23/2013	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.	Y		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.	CHIEF FINANCIAL OFFICER		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: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
2/28/2013 12:42 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	68	10,404	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)		68	10,404	0.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	5	765	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)		73	11,169	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	40.00	26	3,978			16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	1,672			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)		99				27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
2/28/2013 12:42 pm

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	1,464	347	2,720	1.00	
2.00 HMO		243	5		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	1,464	347	2,720	7.00	
8.00 INTENSIVE CARE UNIT	0	246	11	348	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		157	287	13.00	
14.00 Total (see instructions)	0	1,710	515	3,355	14.00	
15.00 CAH visits	0	0	0	0	15.00	
16.00 SUBPROVIDER - IPF	0	696	0	1,910	16.00	
17.00 SUBPROVIDER - IRF					17.00	
18.00 SUBPROVIDER					18.00	
19.00 SKILLED NURSING FACILITY					19.00	
20.00 NURSING FACILITY					20.00	
21.00 OTHER LONG TERM CARE					21.00	
22.00 HOME HEALTH AGENCY	0	2,910	472	4,767	22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00	
24.00 HOSPICE		1,364	83	1,672	24.00	
25.00 CMHC - CMHC					25.00	
26.00 RURAL HEALTH CLINIC					26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25	
27.00 Total (sum of lines 14-26)					27.00	
28.00 Observation Bed Days	0		72	462	28.00	
29.00 Ambulance Trips		0			29.00	
30.00 Employee discount days (see instruction)				0	30.00	
31.00 Employee discount days - IRF				0	31.00	
32.00 Labor & delivery days (see instructions)			78	78	32.00	
33.00 LTCH non-covered days		0			33.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
2/28/2013 12:42 pm

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	507	1.00
2.00 HMO					61	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)	0.00	498.86	0.00	0	507	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	30.73	0.00	0	135	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	21.08	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00	3.88	0.00			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	554.55	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
2/28/2013 12:42 pm

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)	371	1,021		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)	371	1,021		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF	136	468		16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140110		Period: From 05/01/2012 To 09/30/2012		Worksheet S-3 Part II Date/Time Prepared: 2/28/2013 12:42 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 II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	12,168,863	0	12,168,863	488,002.40	24.94	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		72,445	0	72,445	864.00	83.85	3.00
4.00	Physician-Part A - Administrative		329,083	0	329,083	2,794.00	117.78	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		696,002	0	696,002	5,932.00	117.33	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,379,542	19,665	1,399,207	51,063.23	27.40	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		518,780	0	518,780	8,410.60	61.68	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		389,111	0	389,111	4,673.00	83.27	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		3,730,746	0	3,730,746			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0			18.00
19.00	Excluded areas		475,458	0	475,458			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		14,161	0	14,161			21.00
22.00	Physician Part A - Administrative		56,735	0	56,735			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		120,558	0	120,558			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits	4.00	137,680	0	137,680	4,816.98	28.58	26.00
27.00	Administrative & General	5.00	1,348,814	-25,030	1,323,784	55,022.52	24.06	27.00
28.00	Administrative & General under contract (see inst.)		343,810	0	343,810	1,136.90	302.41	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	425,513	0	425,513	21,943.47	19.39	30.00
31.00	Laundry & Linen Service	8.00	15,963	0	15,963	1,613.80	9.89	31.00
32.00	Housekeeping	9.00	315,924	0	315,924	26,800.99	11.79	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	296,643	0	296,643	23,701.65	12.52	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	423,858	0	423,858	10,894.62	38.91	38.00
39.00	Central Services and Supply	14.00	87,589	0	87,589	6,482.70	13.51	39.00
40.00	Pharmacy	15.00	360,933	0	360,933	10,506.20	34.35	40.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 140110		Period: From 05/01/2012 To 09/30/2012		Worksheet S-3 Part II Date/Time Prepared: 2/28/2013 12:42 pm		
	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion 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		
41.00	Medical Records & Medical Records Library	16.00	568,172	0	568,172	30,079.43	18.89	41.00
42.00	Social Service	17.00	69,511	0	69,511	3,444.31	20.18	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet S-3
Part III
Date/Time Prepared:
2/28/2013 12:42 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Pai d Hours Related to Sal ari es i n 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)	11,744,226	0	11,744,226	482,343.30	24.35	1.00
2.00	Excluded area salaries (see instructions)	1,379,542	19,665	1,399,207	51,063.23	27.40	2.00
3.00	Subtotal salaries (line 1 minus line 2)	10,364,684	-19,665	10,345,019	431,280.07	23.99	3.00
4.00	Subtotal other wages & related costs (see inst.)	907,891	0	907,891	13,083.60	69.39	4.00
5.00	Subtotal wage-related costs (see inst.)	3,787,481	0	3,787,481	0.00	36.61	5.00
6.00	Total (sum of lines 3 thru 5)	15,060,056	-19,665	15,040,391	444,363.67	33.85	6.00
7.00	Total overhead cost (see instructions)	4,394,410	-25,030	4,369,380	196,443.57	22.24	7.00

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet S-3
Part IV
Date/Time Prepared:
2/28/2013 12:42 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	412,421	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)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	2,801,966	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	217,200	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	-31,097	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)	37,378	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	99,117	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	834,530	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	16,364	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	9,779	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,397,658	24.00
Part B - Other than Core Related Cost			
25.00	RELOCATION EXPENSE	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet S-3 Part V Date/Time Prepared: 2/28/2013 12:42 pm
Cost Center Description			Contract Labor	Benefit Cost
PART V - Contract Labor and Benefit Cost			1.00	2.00
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0 1.00
2.00	Hospital		0	0 2.00
3.00	Subprovider - IPF		0	0 3.00
4.00	Subprovider - IRF			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 8.00
9.00	Hospital-Based NF			0 9.00
10.00	Hospital-Based OLTC			0 10.00
11.00	Hospital-Based HHA		0	0 11.00
12.00	Separately Certified ASC			0 12.00
13.00	Hospital-Based Hospice		0	0 13.00
14.00	Hospital-Based Health Clinic RHC			0 14.00
15.00	Hospital-Based Health Clinic FQHC			0 15.00
16.00	Hospital-Based-CMHC			0 16.00
17.00	Renal Dialysis			0 17.00
18.00	Other		0	0 18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet S-4
		Component CCN: 147048		Date/Time Prepared: 2/28/2013 12:42 pm
			Home Health Agency I	PPS

		1.00					
0.00	County	LASALLE					0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	197.00	0.00	0.00	0.00	2.00
		Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week			Staff	Contract	Total
		0			1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			7.91	0.00	7.91	5.00
6.00	Direct Nursing Service			39.91	0.00	39.91	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			3.04	0.00	3.04	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.01	0.00	0.01	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.21	0.00	0.21	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.09	0.00	0.09	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			22.23	0.00	22.23	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (col s. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,242	0	74	50	1,366	21.00
22.00	Skilled Nursing Visit Charges	358,182	0	21,601	14,569	394,352	22.00
23.00	Physical Therapy Visits	1,154	0	24	36	1,214	23.00
24.00	Physical Therapy Visit Charges	333,667	0	6,951	10,494	351,112	24.00
25.00	Occupational Therapy Visits	18	0	0	0	18	25.00
26.00	Occupational Therapy Visit Charges	5,274	0	0	0	5,274	26.00
27.00	Speech Pathology Visits	37	0	0	1	38	27.00
28.00	Speech Pathology Visit Charges	10,841	0	0	293	11,134	28.00
29.00	Medical Social Service Visits	15	0	1	1	17	29.00
30.00	Medical Social Service Visit Charges	4,287	0	293	293	4,873	30.00
31.00	Home Health Aide Visits	254	0	3	0	257	31.00
32.00	Home Health Aide Visit Charges	41,904	0	504	0	42,408	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,720	0	102	88	2,910	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)	754,155	0	29,349	25,649	809,153	35.00
36.00	Total Number of Episodes (standard/non outlier)	192		36	9	237	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	36,255	0	1,311	1,143	38,709	38.00

HOSPITAL IDENTIFICATION DATA		Provider CCN: 140110 Component CCN: 141570		Period: From 05/01/2012 To 09/30/2012		Worksheet S-9 Parts I & II Date/Time Prepared: 2/28/2013 12:42 pm	
		Unduplicated Days				Hospice I	
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	
		1.00	2.00	3.00	4.00	5.00	
PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	1.00
2.00	Routine Home Care	1,345	72	250	0	222	2.00
3.00	Inpatient Respite Care	0	0	0	0	0	3.00
4.00	General Inpatient Care	19	11	5	0	3	4.00
5.00	Total Hospice Days	1,364	83	255	0	225	5.00
Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	40	3	7	0	6	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	11.00		0.00			7.00
8.00	Average Length of Stay (Line 5/Line 6)	34.10	27.67	36.43	0.00	37.50	8.00
9.00	Unduplicated Census Count	31	3	5	0	4	9.00

HOSPITAL IDENTIFICATION DATA		Provider CCN: 140110 Component CCN: 141570	Period: From 05/01/2012 To 09/30/2012	Worksheet S-9 Parts I & II Date/Time Prepared: 2/28/2013 12:42 pm
		Hospice I		

		Unduplicated Days	
		Total (sum of cols. 1, 2 & 5)	
		6.00	
PART I - ENROLLMENT DAYS			
1.00	Continuous Home Care	0	1.00
2.00	Routine Home Care	1,639	2.00
3.00	Inpatient Respite Care	0	3.00
4.00	General Inpatient Care	33	4.00
5.00	Total Hospice Days	1,672	5.00
Part II - CENSUS DATA			
6.00	Number of Patients Receiving Hospice Care	49	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)	34.12	8.00
9.00	Unduplicated Census Count	38	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet S-10 Date/Time Prepared: 2/28/2013 12:42 pm
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				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)		0.369475		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		0		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		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		1,210,861		5.00
6.00	Medicaid charges		10,733,794		6.00
7.00	Medicaid cost (line 1 times line 6)		3,965,869		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)		2,755,008		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)		2,755,008		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	2,883,510	0	2,883,510	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,065,385	0	1,065,385	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,065,385	0	1,065,385	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,539,686		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		0		27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		2,539,686		28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		938,350		29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,003,735		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,758,743		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140110

Period: From 05/01/2012 To 09/30/2012

Worksheet A
Date/Time Prepared: 2/28/2013 12:42 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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	CAP REL COSTS-BLDG & FIXT		-687,155	-687,155	33,991	-653,164	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,795,739	1,795,739	15,462	1,811,201	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	137,680	4,568,865	4,706,545	0	4,706,545	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,348,814	4,074,669	5,423,483	-181,036	5,242,447	5.00
7.00	00700	OPERATION OF PLANT	425,513	704,406	1,129,919	17,650	1,147,569	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,963	107,658	123,621	0	123,621	8.00
9.00	00900	HOUSEKEEPING	315,924	64,150	380,074	62	380,136	9.00
10.00	01000	DIETARY	296,643	292,736	589,379	0	589,379	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	423,858	23,873	447,731	0	447,731	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	87,589	16,669	104,258	0	104,258	14.00
15.00	01500	PHARMACY	360,933	45,347	406,280	0	406,280	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	568,172	224,593	792,765	0	792,765	16.00
17.00	01700	SOCIAL SERVICE	69,511	1,189	70,700	0	70,700	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	81,118	81,118	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	29,949	3,952	33,901	0	33,901	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,202,656	93,480	1,296,136	-98,429	1,197,707	30.00
31.00	03100	INTENSIVE CARE UNIT	286,198	9,861	296,059	0	296,059	31.00
40.00	04000	SUBPROVIDER - IPF	713,302	20,698	734,000	20,038	754,038	40.00
43.00	04300	NURSERY	19,236	8,837	28,073	0	28,073	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	271,962	1,225,767	1,497,729	15,936	1,513,665	50.00
51.00	05100	RECOVERY ROOM	65,318	2,925	68,243	0	68,243	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	82,493	82,493	52.00
53.00	05300	ANESTHESIOLOGY	550,885	108,771	659,656	-81,118	578,538	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	845,287	578,017	1,423,304	11,917	1,435,221	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	77,709	62,381	140,090	0	140,090	58.00
60.00	06000	LABORATORY	376,785	696,746	1,073,531	0	1,073,531	60.00
64.00	06400	INTRAVENOUS THERAPY	146,608	61,043	207,651	0	207,651	64.00
65.00	06500	RESPIRATORY THERAPY	218,613	61,276	279,889	0	279,889	65.00
66.00	06600	PHYSICAL THERAPY	602,161	293,414	895,575	0	895,575	66.00
67.00	06700	OCCUPATIONAL THERAPY	35,364	45,547	80,911	0	80,911	67.00
68.00	06800	SPEECH PATHOLOGY	35,352	58,168	93,520	9,513	103,033	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	76,874	76,874	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,529	6,529	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	146,944	146,944	0	146,944	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	264,112	264,112	0	264,112	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	598,725	598,725	0	598,725	73.00
75.00	07500	ASC (NON-DISTINCT PART)	791,350	299,174	1,090,524	-109,026	981,498	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	713,223	165,706	878,929	-20,038	858,891	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	22,795	22,795	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	500,014	423,614	923,628	25,030	948,658	91.00
92.00	09200	OBSERVATION BEDS						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	558,049	119,390	677,439	-1,338	676,101	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	79,373	53,045	132,418	354	132,772	116.00
117.00	06950	HOMEMAKER	2,275	1,400	3,675	6,554	10,229	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,172,269	16,635,732	28,808,001	-64,669	28,743,332	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	-3,406	86,725	83,319	64,669	147,988	192.00
200.00		TOTAL (SUM OF LINES 118-199)	12,168,863	16,722,457	28,891,320	0	28,891,320	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet A
Date/Time Prepared:
2/28/2013 12:42 pm

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	1,539,139	885,975	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,811,201	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	-20,439	4,686,106	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,445	5,243,892	5.00
7.00	00700	OPERATION OF PLANT	-5,333	1,142,236	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-1,143	122,478	8.00
9.00	00900	HOUSEKEEPING	0	380,136	9.00
10.00	01000	DIETARY	-183,185	406,194	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	447,731	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	104,258	14.00
15.00	01500	PHARMACY	0	406,280	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,562	791,203	16.00
17.00	01700	SOCIAL SERVICE	0	70,700	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-81,118	0	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	33,901	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-51,207	1,146,500	30.00
31.00	03100	INTENSIVE CARE UNIT	0	296,059	31.00
40.00	04000	SUBPROVIDER - I/PF	0	754,038	40.00
43.00	04300	NURSERY	0	28,073	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,513,665	50.00
51.00	05100	RECOVERY ROOM	0	68,243	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	82,493	52.00
53.00	05300	ANESTHESIOLOGY	-397,537	181,001	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-11,630	1,423,591	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	140,090	58.00
60.00	06000	LABORATORY	0	1,073,531	60.00
64.00	06400	INTRAVENOUS THERAPY	0	207,651	64.00
65.00	06500	RESPIRATORY THERAPY	0	279,889	65.00
66.00	06600	PHYSICAL THERAPY	-15,219	880,356	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	80,911	67.00
68.00	06800	SPEECH PATHOLOGY	0	103,033	68.00
69.00	06900	ELECTROCARDIOLOGY	-33,664	43,210	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,529	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	-10	146,934	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	264,112	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-4,423	594,302	73.00
75.00	07500	ASC (NON-DISTINCT PART)	-59,423	922,075	75.00
76.00	03160	STRESS TESTING	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-347,110	511,781	76.01
76.97	07697	CARDIAC REHABILITATION	0	22,795	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-8,667	939,991	91.00
92.00	09200	OBSERVATION BEDS			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	-240	675,861	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	-7,307	125,465	116.00
117.00	06950	HOMEMAKER	0	10,229	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	311,367	29,054,699	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	147,988	192.00
200.00		TOTAL (SUM OF LINES 118-199)	311,367	29,202,687	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - PREPAID INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	33,991	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	15,462	2.00
	TOTALS		0	49,453	
B - DELIVERY ROOM					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	92,210	6,219	1.00
	TOTALS		92,210	6,219	
D - EKG, HOLTER, STRESS AND EEG					
1.00	ELECTROCARDIOLOGY	69.00	43,210	33,664	1.00
2.00	CARDIAC REHABILITATION	76.97	22,795	0	2.00
3.00	ELECTROENCEPHALOGRAPHY	70.00	922	0	3.00
	TOTALS		66,927	33,664	
G - ER WARD CLERKS					
1.00	EMERGENCY	91.00	25,030	0	1.00
	TOTALS		25,030	0	
H - HHA SUPERVISOR SALARY					
1.00	HOMEMAKER	117.00	6,554	0	1.00
	TOTALS		6,554	0	
I - C-SECTION					
1.00	OPERATING ROOM	50.00	14,929	1,007	1.00
	TOTALS		14,929	1,007	
K - NONPHYSICIAN ANESTHETISTS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	81,118	1.00
	TOTALS		0	81,118	
M - MOB HOSPITAL STORAGE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,533	1.00
	TOTALS		0	9,533	
O - PSYCHIATRIC ADMIN					
1.00	SUBPROVIDER - IPF	40.00	11,967	8,071	1.00
	TOTALS		11,967	8,071	
U - NORRIS BUILDING OVERHEAD					
1.00	OPERATION OF PLANT	7.00	0	17,650	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,386	2.00
3.00	SPEECH PATHOLOGY	68.00	0	3,647	3.00
4.00	ASC (NON-DISTINCT PART)	75.00	0	12,473	4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	70,930	5.00
	TOTALS		0	116,086	
V - MERCURY CIRCLE OVERHEAD					
1.00	HOUSEKEEPING	9.00	0	62	1.00
2.00	ELECTROENCEPHALOGRAPHY	70.00	0	5,607	2.00
3.00	HOME HEALTH AGENCY	101.00	0	5,216	3.00
4.00	HOSPICE	116.00	0	354	4.00
	TOTALS		0	11,239	
W - RADIOLOGY SPACE					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	531	1.00
	TOTALS		0	531	
Y - GLOBAL BILLING					
1.00	SPEECH PATHOLOGY	68.00	3,238	2,628	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	7,698	7,344	2.00
	TOTALS		10,936	9,972	
500.00	Grand Total: Increases		228,553	326,893	500.00

		Decreases				Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - PREPAID INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	49,453	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	49,453			
B - DELIVERY ROOM							
1.00	ADULTS & PEDIATRICS	30.00	92,210	6,219	0		1.00
	TOTALS		92,210	6,219			
D - EKG, HOLTER, STRESS AND EEG							
1.00	ASC (NON-DISTINCT PART)	75.00	66,927	33,664	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		66,927	33,664			
G - ER WARD CLERKS							
1.00	ADMINISTRATIVE & GENERAL	5.00	25,030	0	0		1.00
	TOTALS		25,030	0			
H - HHA SUPERVISOR SALARY							
1.00	HOME HEALTH AGENCY	101.00	6,554	0	0		1.00
	TOTALS		6,554	0			
I - C-SECTION							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	14,929	1,007	0		1.00
	TOTALS		14,929	1,007			
K - NONPHYSICIAN ANESTHETISTS							
1.00	ANESTHESIOLOGY	53.00	0	81,118	0		1.00
	TOTALS		0	81,118			
M - MOB HOSPITAL STORAGE							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	9,533	0		1.00
	TOTALS		0	9,533			
O - PSYCHIATRIC ADMIN							
1.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01	11,967	8,071	0		1.00
	TOTALS		11,967	8,071			
U - NORRIS BUILDING OVERHEAD							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	116,086	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		0	116,086			
V - MERCURY CIRCLE OVERHEAD							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	11,239	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	11,239			
W - RADIOLOGY SPACE							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	531	0		1.00
	TOTALS		0	531			
Y - GLOBAL BILLING							
1.00	ASC (NON-DISTINCT PART)	75.00	10,936	9,972	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		10,936	9,972			
500.00	Grand Total: Decreases		228,553	326,893			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/28/2013 12:42 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,575,617	1,547,464	0	1,547,464	0	1.00
2.00	Land Improvements	2,862,859	0	0	0	0	2.00
3.00	Buildings and Fixtures	72,330,648	-1,545,261	0	-1,545,261	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	34,084,494	4,932,226	0	4,932,226	0	6.00
7.00	HIT designated Assets	80,645	613,832	0	613,832	0	7.00
8.00	Subtotal (sum of lines 1-7)	110,934,263	5,548,261	0	5,548,261	0	8.00
9.00	Reconciling Items	0	4,789,715	0	4,789,715	0	9.00
10.00	Total (line 8 minus line 9)	110,934,263	758,546	0	758,546	0	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	-701,218	0	14,063	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,795,739	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,094,521	0	14,063	0	0	3.00
COMPUTATION OF RATIOS							
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	77,465,804	0	77,465,804	0.665042	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	39,016,720	0	39,016,720	0.334958	0	2.00
3.00	Total (sum of lines 1-2)	116,482,524	0	116,482,524	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/28/2013 12:42 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,123,081	0		1.00		
2.00	Land Improvements	2,862,859	0		2.00		
3.00	Buildings and Fixtures	70,785,387	0		3.00		
4.00	Building Improvements	0	0		4.00		
5.00	Fixed Equipment	0	0		5.00		
6.00	Movable Equipment	39,016,720	0		6.00		
7.00	HIT designated Assets	694,477	0		7.00		
8.00	Subtotal (sum of lines 1-7)	116,482,524	0		8.00		
9.00	Reconciling Items	4,789,715	0		9.00		
10.00	Total (line 8 minus line 9)	111,692,809	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	-687,155		1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,795,739		2.00		
3.00	Total (sum of lines 1-2)	0	1,108,584		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	-701,218	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,795,739	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,094,521	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet A-7 Parts I-III Date/Time Prepared: 2/28/2013 12:42 pm
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Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,553,202	33,991	0	0	885,975	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	15,462	0	0	1,811,201	2.00
3.00	Total (sum of lines 1-2)	1,553,202	49,453	0	0	2,697,176	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet A-8

Date/Time Prepared:
2/28/2013 12:42 pm

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
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		0.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0	0		0.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0	0		0.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0	0		0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-26,402		ADMINISTRATIVE & GENERAL	5.00	7.00
8.00 Television and radio service (chapter 21)	A	-5,333		OPERATION OF PLANT	7.00	8.00
9.00 Parking lot (chapter 21)		0			0.00	9.00
10.00 Provider-based physician adjustment	A-8-2	-856,598				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	1,053,472				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Cafeteria-employees and guests	B	-183,185		DIETARY	10.00	14.00
15.00 Rental of quarters to employee and others		0			0.00	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	16.00
17.00 Sale of drugs to other than patients	B	-4,423		DRUGS CHARGED TO PATIENTS	73.00	17.00
18.00 Sale of medical records and abstracts	B	-1,562		MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)	B	-9,755		RADIOLOGY-DIAGNOSTIC	54.00	19.00
20.00 Vending machines		0			0.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0		RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0		PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0		*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00 Non-physician Anesthetist	A	-81,118		NONPHYSICIAN ANESTHETISTS	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 AMORTIZED CAPITALIZED INTEREST	A	-14,224		CAP REL COSTS-BLDG & FIXT	1.00	33.00
33.01 PHYSICIAN RECRUITING EXPENSE	A	-20,439		EMPLOYEE BENEFITS	4.00	33.01
33.02 PATIENT TRANSPORTATION	A	-7,260		ADMINISTRATIVE & GENERAL	5.00	33.02
33.03 TRUSTEE FEES	A	1,895		ADMINISTRATIVE & GENERAL	5.00	33.03
33.04 NON ALLOWABLE TAXES	A	-5,500		ADMINISTRATIVE & GENERAL	5.00	33.04
33.05 ADMINISTRATION ALCOHOL	A	-2,602		ADMINISTRATIVE & GENERAL	5.00	33.05
33.06 MISCELLANEOUS EXPENSE	A	-1,156		ADMINISTRATIVE & GENERAL	5.00	33.06
33.07 ADVERTISING	A	-16,200		ADMINISTRATIVE & GENERAL	5.00	33.07
33.08 AHA LOBBYING FEES	A	-1,953		ADMINISTRATIVE & GENERAL	5.00	33.08
33.09 IHA LOBBYING FEES	A	-7,962		ADMINISTRATIVE & GENERAL	5.00	33.09
33.10 I L HOME CARE LOBBYING FEES	A	-15		HOSPICE	116.00	33.10
33.11 PHYSICIAN LOAN WRITE OFF	A	-177,471		ADMINISTRATIVE & GENERAL	5.00	33.11
33.12 ROTARY FEES	A	-425		ADMINISTRATIVE & GENERAL	5.00	33.12
33.13 PHYSICIAN RECRUITING EXPENSE	A	-187		ADMINISTRATIVE & GENERAL	5.00	33.13
33.14 CONTRIBUTIONS	A	-35,000		ADMINISTRATIVE & GENERAL	5.00	33.14
33.15 PHYSICIAN RELATED COST	A	-236		ADMINISTRATIVE & GENERAL	5.00	33.15
33.16 MEDICAL TAX ASSESSMENT - APPEAL	A	-710,281		ADMINISTRATIVE & GENERAL	5.00	33.16
33.17 GOLF OUTINGS	A	-3,311		ADMINISTRATIVE & GENERAL	5.00	33.17
33.18 CABLE SERVICE	A	-421		ASC (NON-DISTINCT PART)	75.00	33.18

Provider CCN: 140110
 Period: From 05/01/2012 To 09/30/2012
 Worksheet A-8
 Date/Time Prepared: 2/28/2013 12:42 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		
			1.00	2.00	
33.19 COMMUNITY EDUCATION REVENUE	B	-3,843	ADMINISTRATIVE & GENERAL	5.00	33.19
33.20 RENT REVENUE	B	-3,800	ASC (NON-DISTINCT PART)	75.00	33.20
33.21 RENT REVENUE	B	-1,143	LAUNDRY & LINEN SERVICE	8.00	33.21
33.22 RENT REVENUE	B	-801	ASC (NON-DISTINCT PART)	75.00	33.22
33.23 RADIOLOGY FILM COPY REVENUE	B	-1,875	RADIOLOGY-DIAGNOSTIC	54.00	33.23
33.24 MISCELLANEOUS REVENUE	B	-1,875	ADULTS & PEDIATRICS	30.00	33.24
33.25 MISCELLANEOUS REVENUE	B	-49,332	ADULTS & PEDIATRICS	30.00	33.25
33.26 STORES MISCELLANEOUS INCOME	B	-10	MEDICAL SUPPLIES CHRGD TO PATIENTS	71.00	33.26
33.27 MISCELLANEOUS FEES	B	27,044	ADMINISTRATIVE & GENERAL	5.00	33.27
33.28 INTEREST ADD ONS	A	-95,240	ADMINISTRATIVE & GENERAL	5.00	33.28
33.29 ASSET REDUCTION ADD-BACK	A	1,567,426	CAP REL COSTS-BLDG & FIXT	1.00	33.29
33.30 HHA PHYSICIAN FEES	A	-240	HOME HEALTH AGENCY	101.00	33.30
33.31 HOSPICE PHYSICIAN FEES	A	-7,292	HOSPICE	116.00	33.31
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		311,367			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet A-8
Date/Time Prepared:
2/28/2013 12:42 pm

Cost Center Description		Wkst. A-7 Ref.		
		5.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0		1.00
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)	0		8.00
9.00	Parking lot (chapter 21)	0		9.00
10.00	Provider-based physician adjustment	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0		11.00
12.00	Related organization transactions (chapter 10)	0		12.00
13.00	Laundry and linen service	0		13.00
14.00	Cafeteria-employees and guests	0		14.00
15.00	Rental of quarters to employee and others	0		15.00
16.00	Sale of medical and surgical supplies to other than patients	0		16.00
17.00	Sale of drugs to other than patients	0		17.00
18.00	Sale of medical records and abstracts	0		18.00
19.00	Nursing school (tuition, fees, books, etc.)	0		19.00
20.00	Vending machines	0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	0		26.00
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	AMORTIZED CAPITALIZED INTEREST	11		33.00
33.01	PHYSICIAN RECRUITING EXPENSE	0		33.01
33.02	PATIENT TRANSPORTATION	0		33.02
33.03	TRUSTEE FEES	0		33.03
33.04	NON ALLOWABLE TAXES	0		33.04
33.05	ADMINISTRATION ALCOHOL	0		33.05
33.06	MISCELLANEOUS EXPENSE	0		33.06
33.07	ADVERTISING	0		33.07
33.08	AHA LOBBYING FEES	0		33.08
33.09	IHA LOBBYING FEES	0		33.09
33.10	IL HOME CARE LOBBYING FEES	0		33.10
33.11	PHYSICIAN LOAN WRITE OFF	0		33.11
33.12	ROTARY FEES	0		33.12
33.13	PHYSICIAN RECRUITING EXPENSE	0		33.13
33.14	CONTRIBUTIONS	0		33.14
33.15	PHYSICIAN RELATED COST	0		33.15
33.16	MEDICAID TAX ASSESSMENT - APPEAL	0		33.16
33.17	GOLF OUTINGS	0		33.17
33.18	CABLE SERVICE	0		33.18
33.19	COMMUNITY EDUCATION REVENUE	0		33.19
33.20	RENT REVENUE	0		33.20
33.21	RENT REVENUE	0		33.21
33.22	RENT REVENUE	0		33.22
33.23	RADIOLOGY FILM COPY REVENUE	0		33.23
33.24	MISCELLANEOUS REVENUE	0		33.24
33.25	MISCELLANEOUS REVENUE	0		33.25

ADJUSTMENTS TO EXPENSES

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet A-8

Date/Time Prepared:
2/28/2013 12:42 pm

Cost Center Description		Wkst. A-7 Ref.		
		5.00		
33.26	STORES MISCELLANEOUS INCOME	0		33.26
33.27	MISCELLANEOUS FEES	0		33.27
33.28	INTEREST ADD ONS	0		33.28
33.29	ASSET REDUCTION ADD-BACK	11		33.29
33.30	HHA PHYSICIAN FEES	0		33.30
33.31	HOSPICE PHYSICIAN FEES	0		33.31
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: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet A-8-1

Date/Time Prepared:
2/28/2013 12:42 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		1.00 CAP REL COSTS-BLDG & FIXT	INTEREST	1.00
2.00		5.00 ADMINISTRATIVE & GENERAL	CORPORATE ALLOCATIONS	2.00
3.00		5.00 ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	3.00
4.00		5.00 ADMINISTRATIVE & GENERAL	NEW BLDG EXPENSE	4.00
4.01		5.00 ADMINISTRATIVE & GENERAL	NEW MME EXPENSE	4.01
4.02		5.00 ADMINISTRATIVE & GENERAL	NONCAPITAL EXPENSE	4.02
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			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:			100.00
		HOME OFFICE		

(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: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet A-8-1 Date/Time Prepared: 2/28/2013 12:42 pm
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	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	0	14,063	-14,063	11	1.00
2.00	0	1,435,053	-1,435,053	0	2.00
3.00	725,968	0	725,968	0	3.00
4.00	36,967	0	36,967	0	4.00
4.01	489,418	0	489,418	0	4.01
4.02	1,250,235	0	1,250,235	0	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	2,502,588	1,449,116	1,053,472	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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	OSF HEALTHCARE	100.00	HOME OFFICE	6.00
7.00		0.00		7.00
8.00		0.00		8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:
2/28/2013 12:42 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	76.01	PSYCHI ATRI C/PSYCHOLOGICAL SERVICES	124,224	105,612	1.00
2.00	76.01	PSYCHI ATRI C/PSYCHOLOGICAL SERVICES	87,273	74,197	2.00
3.00	76.01	PSYCHI ATRI C/PSYCHOLOGICAL SERVICES	40,329	34,287	3.00
4.00	76.01	PSYCHI ATRI C/PSYCHOLOGICAL SERVICES	123,255	104,789	4.00
5.00	53.00	ANESTHESIOLOGY	880	852	5.00
6.00	53.00	ANESTHESIOLOGY	158,220	152,701	6.00
7.00	53.00	ANESTHESIOLOGY	167,441	21,927	7.00
8.00	53.00	ANESTHESIOLOGY	148,255	147,236	8.00
9.00	60.00	LABORATORY	50,000	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	33,664	33,664	10.00
11.00	66.00	PHYSICAL THERAPY	16,667	13,746	11.00
12.00	75.00	ASC (NON-DISTINCT PART)	175,208	54,401	12.00
13.00	91.00	EMERGENCY	278,750	0	13.00
14.00	91.00	EMERGENCY	8,667	8,667	14.00
200.00			1,412,833	752,079	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:
2/28/2013 12:42 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	18,612	154,100	132	9,779	489	1.00
2.00	13,076	154,100	70	5,186	259	2.00
3.00	6,042	154,100	153	11,335	567	3.00
4.00	18,466	154,100	94	6,964	348	4.00
5.00	28	200,300	28	2,696	135	5.00
6.00	5,519	200,300	31	2,985	149	6.00
7.00	145,514	200,300	765	73,668	3,683	7.00
8.00	1,019	200,300	6	578	29	8.00
9.00	50,000	215,700	990	102,665	5,133	9.00
10.00	0	177,200	0	0	0	10.00
11.00	2,921	177,200	17	1,448	72	11.00
12.00	120,807	177,200	1,515	129,066	6,453	12.00
13.00	278,750	177,200	3,433	292,465	14,623	13.00
14.00	0	177,200	0	0	0	14.00
200.00	660,754		7,234	638,835	31,940	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:
2/28/2013 12:42 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	9,779	1.00
2.00	0	0	0	0	5,186	2.00
3.00	0	0	0	0	11,335	3.00
4.00	0	0	0	0	6,964	4.00
5.00	0	0	0	0	2,696	5.00
6.00	0	0	0	0	2,985	6.00
7.00	0	0	0	0	73,668	7.00
8.00	0	0	0	0	578	8.00
9.00	0	0	0	0	102,665	9.00
10.00	0	0	0	0	0	10.00
11.00	0	0	0	0	1,448	11.00
12.00	0	0	0	0	129,066	12.00
13.00	0	0	0	0	292,465	13.00
14.00	0	0	0	0	0	14.00
200.00	0	0	0	0	638,835	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet A-8-2
Date/Time Prepared:
2/28/2013 12:42 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	8,833	114,445	1.00
2.00	7,890	82,087	2.00
3.00	0	34,287	3.00
4.00	11,502	116,291	4.00
5.00	0	852	5.00
6.00	2,534	155,235	6.00
7.00	71,846	93,773	7.00
8.00	441	147,677	8.00
9.00	0	0	9.00
10.00	0	33,664	10.00
11.00	1,473	15,219	11.00
12.00	0	54,401	12.00
13.00	0	0	13.00
14.00	0	8,667	14.00
200.00	104,519	856,598	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet B
Part I
Date/Time Prepared:
2/28/2013 12:42 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	885,975	885,975			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,811,201		1,811,201		2.00
4.00 00400	EMPLOYEE BENEFITS	4,686,106	5,225	336	4,691,667	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,243,892	56,195	305,256	516,221	5.00
7.00 00700	OPERATION OF PLANT	1,142,236	331,384	25,889	165,933	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	122,478	4,416	0	6,225	8.00
9.00 00900	HOUSEKEEPING	380,136	6,647	1,580	123,197	9.00
10.00 01000	DIETARY	406,194	37,247	3,540	115,679	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	447,731	5,550	3,426	165,287	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	104,258	22,003	50,766	34,156	14.00
15.00 01500	PHARMACY	406,280	5,692	26,204	140,749	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	791,203	17,192	23,287	221,564	16.00
17.00 01700	SOCIAL SERVICE	70,700	2,095	61	27,106	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	33,901	2,697	1,949	11,679	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,146,500	81,272	35,668	433,028	30.00
31.00 03100	INTENSIVE CARE UNIT	296,059	9,025	5,644	111,605	31.00
40.00 04000	SUBPROVIDER - IPF	754,038	32,144	5,515	282,825	40.00
43.00 04300	NURSERY	28,073	0	757	7,501	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,513,665	32,483	105,249	111,876	50.00
51.00 05100	RECOVERY ROOM	68,243	3,484	1,440	25,471	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	82,493	0	0	30,136	52.00
53.00 05300	ANESTHESIOLOGY	181,001	0	7,131	214,823	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,423,591	31,649	379,045	329,627	54.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	140,090	9,886	136,655	30,303	58.00
60.00 06000	LABORATORY	1,073,531	29,691	14,476	146,931	60.00
64.00 06400	INTRAVENOUS THERAPY	207,651	0	0	57,171	64.00
65.00 06500	RESPIRATORY THERAPY	279,889	5,579	10,983	85,250	65.00
66.00 06600	PHYSICAL THERAPY	880,356	71,146	22,033	234,818	66.00
67.00 06700	OCCUPATIONAL THERAPY	80,911	4,001	0	13,791	67.00
68.00 06800	SPEECH PATHOLOGY	103,033	2,250	4,107	15,049	68.00
69.00 06900	ELECTROCARDIOLOGY	43,210	0	0	16,850	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	6,529	3,291	7,675	360	70.00
71.00 07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	146,934	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	264,112	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	594,302	0	0	0	73.00
75.00 07500	ASC (NON-DISTINCT PART)	922,075	35,896	86,328	278,231	75.00
76.00 03160	STRESS TESTING	0	0	0	0	76.00
76.01 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	511,781	18,402	171,326	273,461	76.01
76.97 07697	CARDIAC REHABILITATION	22,795	0	0	8,889	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	939,991	19,433	32,427	204,746	91.00
92.00 09200	OBSERVATION BEDS					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	675,861	0	31,170	215,060	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	125,465	0	485	30,952	116.00
117.00 06950	HOMEMAKER	10,229	0	1,768	3,443	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	29,054,699	885,975	1,502,176	4,689,993	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	147,988	0	309,025	1,674	192.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	29,202,687	885,975	1,811,201	4,691,667	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet B Part I Date/Time Prepared: 2/28/2013 12:42 pm
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,121,564				5.00
7.00	00700	OPERATION OF PLANT	441,709	2,107,151			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	35,306	18,867	187,292		8.00
9.00	00900	HOUSEKEEPING	135,676	28,401	0	675,637	9.00
10.00	01000	DIETARY	149,229	159,143	0	12,495	883,527
11.00	01100	CAFETERIA	0	0	0	9,996	699,005
13.00	01300	NURSING ADMINISTRATION	164,965	23,715	0	17,493	0
14.00	01400	CENTRAL SERVICES & SUPPLY	56,010	94,013	0	1,266	0
15.00	01500	PHARMACY	153,542	24,318	0	7,497	0
16.00	01600	MEDICAL RECORDS & LIBRARY	279,342	73,457	0	9,996	0
17.00	01700	SOCIAL SERVICE	26,512	8,951	0	909	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	13,321	11,525	0	7,140	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	449,937	347,247	65,145	199,918	92,133
31.00	03100	INTENSIVE CARE UNIT	112,011	38,559	7,454	17,493	7,068
40.00	04000	SUBPROVIDER - IPF	284,985	137,339	8,168	19,992	77,636
43.00	04300	NURSERY	9,636	0	340	4,998	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	467,655	138,787	8,320	46,410	0
51.00	05100	RECOVERY ROOM	26,161	14,884	1,820	3,570	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,871	0	0	4,998	0
53.00	05300	ANESTHESIOLOGY	106,872	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	573,900	135,227	16,113	22,686	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	84,057	42,240	0	4,998	0
60.00	06000	LABORATORY	335,405	126,860	0	19,992	0
64.00	06400	INTRAVENOUS THERAPY	70,236	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	101,235	23,835	0	4,998	0
66.00	06600	PHYSICAL THERAPY	320,479	303,984	7,747	32,487	0
67.00	06700	OCCUPATIONAL THERAPY	26,178	17,097	7,747	0	0
68.00	06800	SPEECH PATHOLOGY	33,004	9,615	7,747	1,655	0
69.00	06900	ELECTROCARDIOLOGY	15,929	0	0	2,499	0
70.00	07000	ELECTROENCEPHALOGRAPHY	4,736	14,060	0	1,785	0
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	38,970	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	70,048	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	157,621	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	350,761	153,370	17,157	57,087	4,805
76.00	03160	STRESS TESTING	0	0	0	0	0
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	258,582	78,626	6,351	48,552	298
76.97	07697	CARDIAC REHABILITATION	8,403	0	0	2,499	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	317,361	83,031	33,183	59,976	2,582
92.00	09200	OBSERVATION BEDS					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	244,557	0	0	19,992	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	41,614	0	0	0	0
117.00	06950	HOMEMAKER	4,095	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,999,911	2,107,151	187,292	643,377	883,527
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	121,653	0	0	32,260	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	6,121,564	2,107,151	187,292	675,637	883,527

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet B Part I Date/Time Prepared: 2/28/2013 12:42 pm
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	13.00	14.00	15.00	16.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.00	00500						5.00	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000						10.00	
11.00	01100	709,001					11.00	
13.00	01300	22,287	850,454				13.00	
14.00	01400	15,237	0	377,709			14.00	
15.00	01500	24,685	0	0	788,967		15.00	
16.00	01600	67,026	153,316	0	0	1,636,383	16.00	
17.00	01700	8,084	0	0	0	400	17.00	
19.00	01900	0	0	0	0	0	19.00	
23.00	02300	5,541	12,685	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	103,597	236,992	2,139	0	122,078	30.00	
31.00	03100	12,074	27,605	2,663	0	18,378	31.00	
40.00	04000	48,171	110,183	0	0	163,879	40.00	
43.00	04300	0	0	0	0	15,055	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	24,892	56,951	0	0	14,814	50.00	
51.00	05100	3,887	8,879	0	0	4,444	51.00	
52.00	05200	7,567	17,312	0	0	681	52.00	
53.00	05300	12,322	0	895	0	4,524	53.00	
54.00	05400	82,552	0	0	0	450,718	54.00	
58.00	05800	5,582	0	0	0	0	58.00	
60.00	06000	37,027	0	0	0	16,816	60.00	
64.00	06400	0	0	11,343	0	801	64.00	
65.00	06500	14,410	0	0	0	320	65.00	
66.00	06600	63,904	0	0	0	30,870	66.00	
67.00	06700	2,047	0	0	0	7,447	67.00	
68.00	06800	3,142	0	0	0	14,854	68.00	
69.00	06900	4,073	0	0	0	49,848	69.00	
70.00	07000	83	0	0	0	280	70.00	
71.00	07100	0	0	306,434	0	0	71.00	
72.00	07200	0	0	52,372	0	0	72.00	
73.00	07300	0	0	0	788,967	1,201	73.00	
75.00	07500	52,409	119,879	0	0	236,829	75.00	
76.00	03160	0	0	0	0	0	76.00	
76.01	03550	38,516	0	0	0	330,039	76.01	
76.97	07697	2,150	0	0	0	1,521	76.97	
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	46,620	106,652	1,863	0	150,586	91.00	
92.00	09200						92.00	
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	0	0	0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300						113.00	
116.00	11600	0	0	0	0	0	116.00	
117.00	06950	0	0	0	0	0	117.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)		707,885	850,454	377,709	788,967	1,636,383	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	0	0	0	0	0	190.00	
192.00	19200	1,116	0	0	0	0	192.00	
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers						201.00	
202.00	TOTAL (sum lines 118-201)		709,001	850,454	377,709	788,967	1,636,383	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140110

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Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		17.00	19.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
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
14.00	01400						14.00
15.00	01500						15.00
16.00	01600						16.00
17.00	01700	144,818					17.00
19.00	01900		0				19.00
23.00	02300		0	100,438			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	130,004	0	8,649	3,454,307	0	30.00
31.00	03100	9,977	0	13,764	689,379	0	31.00
40.00	04000	0	0	0	1,924,875	0	40.00
43.00	04300	0	0	0	66,360	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	2,521,102	0	50.00
51.00	05100	0	0	0	162,283	0	51.00
52.00	05200	0	0	0	173,058	0	52.00
53.00	05300	0	0	0	527,568	0	53.00
54.00	05400	0	0	0	3,445,108	0	54.00
58.00	05800	0	0	0	453,811	0	58.00
60.00	06000	0	0	13,113	1,813,842	0	60.00
64.00	06400	0	0	0	347,202	0	64.00
65.00	06500	0	0	26,504	553,003	0	65.00
66.00	06600	0	0	0	1,967,824	0	66.00
67.00	06700	0	0	0	159,219	0	67.00
68.00	06800	0	0	0	194,456	0	68.00
69.00	06900	0	0	0	132,409	0	69.00
70.00	07000	0	0	0	38,799	0	70.00
71.00	07100	0	0	0	492,338	0	71.00
72.00	07200	0	0	0	386,532	0	72.00
73.00	07300	0	0	0	1,542,091	0	73.00
75.00	07500	1,310	0	0	2,316,137	0	75.00
76.00	03160	0	0	0	0	0	76.00
76.01	03550	0	0	0	1,735,934	0	76.01
76.97	07697	0	0	0	46,257	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	3,527	0	38,408	2,040,386	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	1,186,640	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	198,516	0	116.00
117.00	06950	0	0	0	19,535	0	117.00
118.00		144,818	0	100,438	28,588,971	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	613,716	0	192.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		144,818	0	100,438	29,202,687	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140110

Period:
From 05/01/2012
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
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
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - I/PF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
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 CHRGD TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
76.00	03160	STRESS TESTING	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS	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
117.00	06950	HOMEMAKER	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	5,225	336	5,561	5,561 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	56,195	305,256	361,451	612 5.00
7.00 00700	OPERATION OF PLANT	0	331,384	25,889	357,273	197 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	4,416	0	4,416	7 8.00
9.00 00900	HOUSEKEEPING	0	6,647	1,580	8,227	146 9.00
10.00 01000	DIETARY	0	37,247	3,540	40,787	137 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	0	5,550	3,426	8,976	196 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	22,003	50,766	72,769	40 14.00
15.00 01500	PHARMACY	0	5,692	26,204	31,896	167 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	17,192	23,287	40,479	262 16.00
17.00 01700	SOCIAL SERVICE	0	2,095	61	2,156	32 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	2,697	1,949	4,646	14 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	81,272	35,668	116,940	513 30.00
31.00 03100	INTENSIVE CARE UNIT	0	9,025	5,644	14,669	132 31.00
40.00 04000	SUBPROVIDER - I/PF	0	32,144	5,515	37,659	335 40.00
43.00 04300	NURSERY	0	0	757	757	9 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	32,483	105,249	137,732	133 50.00
51.00 05100	RECOVERY ROOM	0	3,484	1,440	4,924	30 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	36 52.00
53.00 05300	ANESTHESIOLOGY	0	0	7,131	7,131	255 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	31,649	379,045	410,694	391 54.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	9,886	136,655	146,541	36 58.00
60.00 06000	LABORATORY	0	29,691	14,476	44,167	174 60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	68 64.00
65.00 06500	RESPIRATORY THERAPY	0	5,579	10,983	16,562	101 65.00
66.00 06600	PHYSICAL THERAPY	0	71,146	22,033	93,179	278 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	4,001	0	4,001	16 67.00
68.00 06800	SPEECH PATHOLOGY	0	2,250	4,107	6,357	18 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	20 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	3,291	7,675	10,966	0 70.00
71.00 07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	35,896	86,328	122,224	330 75.00
76.00 03160	STRESS TESTING	0	0	0	0	0 76.00
76.01 03550	PSYCHIATRICAL/PSYCHOLOGICAL SERVICES	0	18,402	171,326	189,728	324 76.01
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	11 76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	19,433	32,427	51,860	243 91.00
92.00 09200	OBSERVATION BEDS				0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	0	31,170	31,170	255 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	0	0	485	485	37 116.00
117.00 06950	HOMEMAKER	0	0	1,768	1,768	4 117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	885,975	1,502,176	2,388,151	5,559 118.00
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	309,025	309,025	2 192.00
200.00	Cross Foot Adjustments				0	0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	885,975	1,811,201	2,697,176	5,561 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/28/2013 12:42 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	362,063				5.00	
7.00	00700	OPERATION OF PLANT	26,126	383,596			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	2,088	3,435	9,946		8.00	
9.00	00900	HOUSEKEEPING	8,025	5,170	0	21,568	9.00	
10.00	01000	DIETARY	8,826	28,971	0	399	79,120	10.00
11.00	01100	CAFETERIA	0	0	0	319	62,597	11.00
13.00	01300	NURSING ADMINISTRATION	9,757	4,317	0	558	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,313	17,115	0	40	0	14.00
15.00	01500	PHARMACY	9,082	4,427	0	239	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,522	13,372	0	319	0	16.00
17.00	01700	SOCIAL SERVICE	1,568	1,629	0	29	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMED PRGM-(SPECIFY)	788	2,098	0	228	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,612	63,218	3,460	6,381	8,250	30.00
31.00	03100	INTENSIVE CARE UNIT	6,625	7,019	396	558	633	31.00
40.00	04000	SUBPROVIDER - IPF	16,856	25,002	434	638	6,952	40.00
43.00	04300	NURSERY	570	0	18	160	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	27,660	25,265	442	1,482	0	50.00
51.00	05100	RECOVERY ROOM	1,547	2,710	97	114	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,767	0	0	160	0	52.00
53.00	05300	ANESTHESIOLOGY	6,321	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,938	24,617	856	724	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,972	7,689	0	160	0	58.00
60.00	06000	LABORATORY	19,838	23,094	0	638	0	60.00
64.00	06400	INTRAVENOUS THERAPY	4,154	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,988	4,339	0	160	0	65.00
66.00	06600	PHYSICAL THERAPY	18,955	55,339	411	1,037	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,548	3,112	411	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,952	1,750	411	53	0	68.00
69.00	06900	ELECTROCARDIOLOGY	942	0	0	80	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	280	2,560	0	57	0	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	2,305	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,143	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,323	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	20,747	27,920	911	1,822	430	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	15,294	14,313	337	1,550	27	76.01
76.97	07697	CARDIAC REHABILITATION	497	0	0	80	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	18,771	15,115	1,762	1,915	231	91.00
92.00	09200	OBSERVATION BEDS						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	14,465	0	0	638	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,461	0	0	0	0	116.00
117.00	06950	HOMEMAKER	242	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	354,868	383,596	9,946	20,538	79,120	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	7,195	0	0	1,030	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	362,063	383,596	9,946	21,568	79,120	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/28/2013 12:42 pm
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	62,916					11.00
13.00	01300	1,978	25,782				13.00
14.00	01400	1,352	0	94,629			14.00
15.00	01500	2,191	0	0	48,002		15.00
16.00	01600	5,948	4,648	0	0	81,550	16.00
17.00	01700	717	0	0	0	20	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	492	385	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	9,192	7,184	536	0	6,084	30.00
31.00	03100	1,071	837	667	0	916	31.00
40.00	04000	4,275	3,340	0	0	8,167	40.00
43.00	04300	0	0	0	0	750	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,209	1,727	0	0	738	50.00
51.00	05100	345	269	0	0	221	51.00
52.00	05200	671	525	0	0	34	52.00
53.00	05300	1,093	0	224	0	225	53.00
54.00	05400	7,326	0	0	0	22,462	54.00
58.00	05800	495	0	0	0	0	58.00
60.00	06000	3,286	0	0	0	838	60.00
64.00	06400	0	0	2,842	0	40	64.00
65.00	06500	1,279	0	0	0	16	65.00
66.00	06600	5,671	0	0	0	1,538	66.00
67.00	06700	182	0	0	0	371	67.00
68.00	06800	279	0	0	0	740	68.00
69.00	06900	361	0	0	0	2,484	69.00
70.00	07000	7	0	0	0	14	70.00
71.00	07100	0	0	76,772	0	0	71.00
72.00	07200	0	0	13,121	0	0	72.00
73.00	07300	0	0	0	48,002	60	73.00
75.00	07500	4,651	3,634	0	0	11,803	75.00
76.00	03160	0	0	0	0	0	76.00
76.01	03550	3,418	0	0	0	16,448	76.01
76.97	07697	191	0	0	0	76	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	4,137	3,233	467	0	7,505	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	0	0	116.00
117.00	06950	0	0	0	0	0	117.00
118.00		62,817	25,782	94,629	48,002	81,550	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	99	0	0	0	0	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		62,916	25,782	94,629	48,002	81,550	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/28/2013 12:42 pm		
Cost Center	Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
		17.00	19.00	23.00	24.00	25.00
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
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
14.00	01400					14.00
15.00	01500					15.00
16.00	01600					16.00
17.00	01700	6,151				17.00
19.00	01900		0			19.00
23.00	02300			8,651		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	5,521			253,891	0 30.00
31.00	03100	424			33,947	0 31.00
40.00	04000				103,658	0 40.00
43.00	04300				2,264	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	0			197,388	0 50.00
51.00	05100	0			10,257	0 51.00
52.00	05200	0			3,193	0 52.00
53.00	05300	0			15,249	0 53.00
54.00	05400	0			501,008	0 54.00
58.00	05800	0			159,893	0 58.00
60.00	06000	0			92,035	0 60.00
64.00	06400	0			7,104	0 64.00
65.00	06500	0			28,445	0 65.00
66.00	06600	0			176,408	0 66.00
67.00	06700	0			9,641	0 67.00
68.00	06800	0			11,560	0 68.00
69.00	06900	0			3,887	0 69.00
70.00	07000	0			13,884	0 70.00
71.00	07100	0			79,077	0 71.00
72.00	07200	0			17,264	0 72.00
73.00	07300	0			57,385	0 73.00
75.00	07500	56			194,528	0 75.00
76.00	03160	0			0	0 76.00
76.01	03550	0			241,439	0 76.01
76.97	07697	0			855	0 76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	150			105,389	0 91.00
92.00	09200					0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	0			46,528	0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
116.00	11600	0			2,983	0 116.00
117.00	06950	0			2,014	0 117.00
118.00		6,151	0	0	2,371,174	0 118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0			0	0 190.00
192.00	19200	0			317,351	0 192.00
200.00			0	8,651	8,651	0 200.00
201.00		0	0	0	0	0 201.00
202.00		6,151	0	8,651	2,697,176	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/28/2013 12:42 pm
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
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
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - I/PF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
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 CHRGD TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
76.00	03160	STRESS TESTING	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS	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
117.00	06950	HOMEMAKER	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet B-1

Date/Time Prepared:
2/28/2013 12:42 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	188,200				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		1,927,235			2.00
4.00 00400	EMPLOYEE BENEFITS	1,110	357	12,031,183		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	11,937	324,812	1,323,784	-6,121,564	23,081,123 5.00
7.00 00700	OPERATION OF PLANT	70,393	27,548	425,513	0	1,665,442 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	938	0	15,963	0	133,119 8.00
9.00 00900	HOUSEKEEPING	1,412	1,681	315,924	0	511,560 9.00
10.00 01000	DIETARY	7,912	3,767	296,643	0	562,660 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	1,179	3,646	423,858	0	621,994 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	4,674	54,018	87,589	0	211,183 14.00
15.00 01500	PHARMACY	1,209	27,883	360,933	0	578,925 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,652	24,779	568,172	0	1,053,246 16.00
17.00 01700	SOCIAL SERVICE	445	65	69,511	0	99,962 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
23.00 02300	PARAMED PRGM-(SPECIFY)	573	2,074	29,949	0	50,226 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	17,264	37,953	1,110,446	0	1,696,468 30.00
31.00 03100	INTENSIVE CARE UNIT	1,917	6,006	286,198	0	422,333 31.00
40.00 04000	SUBPROVIDER - I/PF	6,828	5,868	725,269	0	1,074,522 40.00
43.00 04300	NURSERY	0	806	19,236	0	36,331 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	6,900	111,992	286,891	0	1,763,273 50.00
51.00 05100	RECOVERY ROOM	740	1,532	65,318	0	98,638 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	77,281	0	112,629 52.00
53.00 05300	ANESTHESIOLOGY	0	7,588	550,885	0	402,955 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	6,723	403,329	845,287	0	2,163,912 54.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	2,100	145,410	77,709	0	316,934 58.00
60.00 06000	LABORATORY	6,307	15,403	376,785	0	1,264,629 60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	146,608	0	264,822 64.00
65.00 06500	RESPIRATORY THERAPY	1,185	11,687	218,613	0	381,701 65.00
66.00 06600	PHYSICAL THERAPY	15,113	23,444	602,161	0	1,208,353 66.00
67.00 06700	OCCUPATIONAL THERAPY	850	0	35,364	0	98,703 67.00
68.00 06800	SPEECH PATHOLOGY	478	4,370	38,590	0	124,439 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	43,210	0	60,060 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	699	8,167	922	0	17,855 70.00
71.00 07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	146,934 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	264,112 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	594,302 73.00
75.00 07500	ASC (NON-DISTINCT PART)	7,625	91,858	713,487	0	1,322,530 75.00
76.00 03160	STRESS TESTING	0	0	0	0	0 76.00
76.01 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,909	182,302	701,256	0	974,970 76.01
76.97 07697	CARDIAC REHABILITATION	0	0	22,795	0	31,684 76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	4,128	34,504	525,044	0	1,196,597 91.00
92.00 09200	OBSERVATION BEDS					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	33,167	551,495	0	922,091 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	0	516	79,373	0	156,902 116.00
117.00 06950	HOMEMAKER	0	1,881	8,829	0	15,440 117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	188,200	1,598,413	12,026,891	-6,121,564	22,622,436 118.00
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	328,822	4,292	0	458,687 192.00
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	885,975	1,811,201	4,691,667		6,121,564 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	4.707625	0.939793	0.389959		0.265220 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			5,561		362,063 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000462		0.015687 205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 140110		Period: From 05/01/2012 To 09/30/2012		Worksheet B-1		
Date/Time Prepared: 2/28/2013 12:42 pm								
Cost Center	Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	104,760				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	938	215,616			8.00	
9.00	00900	HOUSEKEEPING	1,412	0	20,818		9.00	
10.00	01000	DIETARY	7,912	0	385	85,876	10.00	
11.00	01100	CAFETERIA	0	0	308	67,941	34,294	11.00
13.00	01300	NURSING ADMINISTRATION	1,179	0	539	0	1,078	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,674	0	39	0	737	14.00
15.00	01500	PHARMACY	1,209	0	231	0	1,194	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,652	0	308	0	3,242	16.00
17.00	01700	SOCIAL SERVICE	445	0	28	0	391	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	573	0	220	0	268	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,264	74,996	6,160	8,955	5,011	30.00
31.00	03100	INTENSIVE CARE UNIT	1,917	8,581	539	687	584	31.00
40.00	04000	SUBPROVIDER - IPF	6,828	9,403	616	7,546	2,330	40.00
43.00	04300	NURSERY	0	391	154	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,900	9,578	1,430	0	1,204	50.00
51.00	05100	RECOVERY ROOM	740	2,095	110	0	188	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	154	0	366	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	596	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,723	18,550	699	0	3,993	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,100	0	154	0	270	58.00
60.00	06000	LABORATORY	6,307	0	616	0	1,791	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,185	0	154	0	697	65.00
66.00	06600	PHYSICAL THERAPY	15,113	8,919	1,001	0	3,091	66.00
67.00	06700	OCCUPATIONAL THERAPY	850	8,919	0	0	99	67.00
68.00	06800	SPEECH PATHOLOGY	478	8,919	51	0	152	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	77	0	197	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	699	0	55	0	4	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	7,625	19,752	1,759	467	2,535	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,909	7,312	1,496	29	1,863	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	77	0	104	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	4,128	38,201	1,848	251	2,255	91.00
92.00	09200	OBSERVATION BEDS						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	616	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
117.00	06950	HOMEMAKER	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	104,760	215,616	19,824	85,876	34,240	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	994	0	54	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,107,151	187,292	675,637	883,527	709,001	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.114080	0.868637	32.454462	10.288404	20.674200	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	383,596	9,946	21,568	79,120	62,916	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.661665	0.046128	1.036027	0.921328	1.834607	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet B-1
Date/Time Prepared:
2/28/2013 12:42 pm

Cost Center Description		NURSING ADMINISTRATIVE (HOURS SUPERVISED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	158,230					13.00
14.00	01400	0	51,912				14.00
15.00	01500	0	0	598,725			15.00
16.00	01600	28,525	0	0	40,870		16.00
17.00	01700	0	0	0	10	1,437	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	2,360	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	44,093	294	0	3,049	1,290	30.00
31.00	03100	5,136	366	0	459	99	31.00
40.00	04000	20,500	0	0	4,093	0	40.00
43.00	04300	0	0	0	376	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	10,596	0	0	370	0	50.00
51.00	05100	1,652	0	0	111	0	51.00
52.00	05200	3,221	0	0	17	0	52.00
53.00	05300	0	123	0	113	0	53.00
54.00	05400	0	0	0	11,257	0	54.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	0	0	420	0	60.00
64.00	06400	0	1,559	0	20	0	64.00
65.00	06500	0	0	0	8	0	65.00
66.00	06600	0	0	0	771	0	66.00
67.00	06700	0	0	0	186	0	67.00
68.00	06800	0	0	0	371	0	68.00
69.00	06900	0	0	0	1,245	0	69.00
70.00	07000	0	0	0	7	0	70.00
71.00	07100	0	42,116	0	0	0	71.00
72.00	07200	0	7,198	0	0	0	72.00
73.00	07300	0	0	598,725	30	0	73.00
75.00	07500	22,304	0	0	5,915	13	75.00
76.00	03160	0	0	0	0	0	76.00
76.01	03550	0	0	0	8,243	0	76.01
76.97	07697	0	0	0	38	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	19,843	256	0	3,761	35	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	0	0	116.00
117.00	06950	0	0	0	0	0	117.00
118.00		158,230	51,912	598,725	40,870	1,437	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00							201.00
202.00		850,454	377,709	788,967	1,636,383	144,818	202.00
203.00		5.374796	7.275948	1.317745	40.038733	100.778010	203.00
204.00		25,782	94,629	48,002	81,550	6,151	204.00
205.00		0.162940	1.822873	0.080174	1.995351	4.280445	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet B-1
Date/Time Prepared:
2/28/2013 12:42 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)	
		19.00	23.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
2.00	00200			2.00
4.00	00400			4.00
5.00	00500			5.00
7.00	00700			7.00
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
14.00	01400			14.00
15.00	01500			15.00
16.00	01600			16.00
17.00	01700			17.00
19.00	01900	0		19.00
23.00	02300		1,080	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000		93	30.00
31.00	03100		148	31.00
40.00	04000		0	40.00
43.00	04300		0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	0	0	50.00
51.00	05100	0	0	51.00
52.00	05200	0	0	52.00
53.00	05300	0	0	53.00
54.00	05400	0	0	54.00
58.00	05800	0	0	58.00
60.00	06000	0	141	60.00
64.00	06400	0	0	64.00
65.00	06500	0	285	65.00
66.00	06600	0	0	66.00
67.00	06700	0	0	67.00
68.00	06800	0	0	68.00
69.00	06900	0	0	69.00
70.00	07000	0	0	70.00
71.00	07100	0	0	71.00
72.00	07200	0	0	72.00
73.00	07300	0	0	73.00
75.00	07500	0	0	75.00
76.00	03160	0	0	76.00
76.01	03550	0	0	76.01
76.97	07697	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	0	413	91.00
92.00	09200			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300			113.00
116.00	11600	0	0	116.00
117.00	06950	0	0	117.00
118.00		0	1,080	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	0	0	190.00
192.00	19200	0	0	192.00
200.00				200.00
201.00				201.00
202.00		0	100,438	202.00
203.00		0.000000	92.998148	203.00
204.00		0	8,651	204.00
205.00		0.000000	8.010185	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/28/2013 12:42 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	3,454,307		3,454,307	0	3,454,307	30.00
31.00 03100 INTENSIVE CARE UNIT	689,379		689,379	0	689,379	31.00
40.00 04000 SUBPROVIDER - IPF	1,924,875		1,924,875	0	1,924,875	40.00
43.00 04300 NURSERY	66,360		66,360	0	66,360	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2,521,102		2,521,102	0	2,521,102	50.00
51.00 05100 RECOVERY ROOM	162,283		162,283	0	162,283	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	173,058		173,058	0	173,058	52.00
53.00 05300 ANESTHESIOLOGY	527,568		527,568	74,821	602,389	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	3,445,108		3,445,108	0	3,445,108	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	453,811		453,811	0	453,811	58.00
60.00 06000 LABORATORY	1,813,842		1,813,842	0	1,813,842	60.00
64.00 06400 INTRAVENOUS THERAPY	347,202		347,202	0	347,202	64.00
65.00 06500 RESPIRATORY THERAPY	553,003	0	553,003	0	553,003	65.00
66.00 06600 PHYSICAL THERAPY	1,967,824	0	1,967,824	1,473	1,969,297	66.00
67.00 06700 OCCUPATIONAL THERAPY	159,219	0	159,219	0	159,219	67.00
68.00 06800 SPEECH PATHOLOGY	194,456	0	194,456	0	194,456	68.00
69.00 06900 ELECTROCARDIOLOGY	132,409		132,409	0	132,409	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	38,799		38,799	0	38,799	70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	492,338		492,338	0	492,338	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	386,532		386,532	0	386,532	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,542,091		1,542,091	0	1,542,091	73.00
75.00 07500 ASC (NON-DISTINCT PART)	2,316,137		2,316,137	0	2,316,137	75.00
76.00 03160 STRESS TESTING	0		0	0	0	76.00
76.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,735,934		1,735,934	28,225	1,764,159	76.01
76.97 07697 CARDIAC REHABILITATION	46,257		46,257	0	46,257	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	2,040,386		2,040,386	0	2,040,386	91.00
92.00 09200 OBSERVATION BEDS	501,538		501,538		501,538	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	1,186,640		1,186,640		1,186,640	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPICE	198,516		198,516		198,516	116.00
117.00 06950 HOMEMAKER	19,535		19,535		19,535	117.00
200.00	Subtotal (see instructions)	0	29,090,509	104,519	29,195,028	200.00
201.00	Less Observation Beds		501,538		501,538	201.00
202.00	Total (see instructions)	0	28,588,971	104,519	28,693,490	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet C
Part I
Date/Time Prepared:
2/28/2013 12:42 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,416,152		4,416,152		30.00
31.00	03100	INTENSIVE CARE UNIT	787,019		787,019		31.00
40.00	04000	SUBPROVIDER - I/PF	3,078,085		3,078,085		40.00
43.00	04300	NURSERY	215,824		215,824		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,770,248	6,721,227	8,491,475	0.296898	50.00
51.00	05100	RECOVERY ROOM	176,864	784,169	961,033	0.168863	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	658,052	453,812	1,111,864	0.155647	52.00
53.00	05300	ANESTHESIOLOGY	303,890	1,233,752	1,537,642	0.343102	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,371,403	13,246,551	15,617,954	0.220586	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	147,094	2,768,912	2,916,006	0.155628	58.00
60.00	06000	LABORATORY	3,329,306	5,935,010	9,264,316	0.195788	60.00
64.00	06400	INTRAVENOUS THERAPY	699,695	312,671	1,012,366	0.342961	64.00
65.00	06500	RESPIRATORY THERAPY	2,138,115	569,264	2,707,379	0.204258	65.00
66.00	06600	PHYSICAL THERAPY	339,921	2,919,351	3,259,272	0.603762	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,177	371,719	412,896	0.385615	67.00
68.00	06800	SPEECH PATHOLOGY	7,070	100,579	107,649	1.806389	68.00
69.00	06900	ELECTROCARDIOLOGY	276,117	240,294	516,411	0.256402	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,432	13,692	24,124	1.608315	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	458,561	283,044	741,605	0.663882	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	409,079	329,506	738,585	0.523341	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,917,579	1,616,187	3,533,766	0.436387	73.00
75.00	07500	ASC (NON-DISTINCT PART)	425,143	4,551,262	4,976,405	0.465424	75.00
76.00	03160	STRESS TESTING	0	0	0	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	676,917	676,917	2.564471	76.01
76.97	07697	CARDIAC REHABILITATION	35,384	542,485	577,869	0.080048	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,601,632	5,831,460	7,433,092	0.274500	91.00
92.00	09200	OBSERVATION BEDS	47,081	402,676	449,757	1.115131	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	1,010,189	1,010,189		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	797,444	797,444		116.00
117.00	06950	HOMEMAKER	0	4,252	4,252		117.00
200.00		Subtotal (see instructions)	25,660,923	51,716,425	77,377,348		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	25,660,923	51,716,425	77,377,348		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/28/2013 12:42 pm
		Title XVII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		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
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.296898		50.00
51.00	05100 RECOVERY ROOM	0.168863		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.155647		52.00
53.00	05300 ANESTHESIOLOGY	0.391762		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.220586		54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.155628		58.00
60.00	06000 LABORATORY	0.195788		60.00
64.00	06400 INTRAVENOUS THERAPY	0.342961		64.00
65.00	06500 RESPIRATORY THERAPY	0.204258		65.00
66.00	06600 PHYSICAL THERAPY	0.604214		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.385615		67.00
68.00	06800 SPEECH PATHOLOGY	1.806389		68.00
69.00	06900 ELECTROCARDIOLOGY	0.256402		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.608315		70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0.663882		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.523341		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.436387		73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.465424		75.00
76.00	03160 STRESS TESTING	0.000000		76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2.606167		76.01
76.97	07697 CARDIAC REHABILITATION	0.080048		76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.274500		91.00
92.00	09200 OBSERVATION BEDS	1.115131		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
117.00	06950 HOMEMAKER			117.00
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: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet C
Part I
Date/Time Prepared:
2/28/2013 12:42 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	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	3,454,307		3,454,307	0	0 30.00
31.00	03100 INTENSIVE CARE UNIT	689,379		689,379	0	0 31.00
40.00	04000 SUBPROVIDER - IPF	1,924,875		1,924,875	0	0 40.00
43.00	04300 NURSERY	66,360		66,360	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,521,102		2,521,102	0	0 50.00
51.00	05100 RECOVERY ROOM	162,283		162,283	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	173,058		173,058	0	0 52.00
53.00	05300 ANESTHESIOLOGY	527,568		527,568	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,445,108		3,445,108	0	0 54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	453,811		453,811	0	0 58.00
60.00	06000 LABORATORY	1,813,842		1,813,842	0	0 60.00
64.00	06400 INTRAVENOUS THERAPY	347,202		347,202	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	553,003	0	553,003	0	0 65.00
66.00	06600 PHYSICAL THERAPY	1,967,824	0	1,967,824	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	159,219	0	159,219	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	194,456	0	194,456	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	132,409		132,409	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	38,799		38,799	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	492,338		492,338	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	386,532		386,532	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,542,091		1,542,091	0	0 73.00
75.00	07500 ASC (NON-DISTINCT PART)	2,316,137		2,316,137	0	0 75.00
76.00	03160 STRESS TESTING	0		0	0	0 76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,735,934		1,735,934	0	0 76.01
76.97	07697 CARDIAC REHABILITATION	46,257		46,257	0	0 76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	2,040,386		2,040,386	0	0 91.00
92.00	09200 OBSERVATION BEDS	501,538		501,538	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1,186,640		1,186,640		0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
116.00	11600 HOSPICE	198,516		198,516		0 116.00
117.00	06950 HOME MAKER	19,535		19,535		0 117.00
200.00	Subtotal (see instructions)	29,090,509	0	29,090,509	0	0 200.00
201.00	Less Observation Beds	501,538		501,538		0 201.00
202.00	Total (see instructions)	28,588,971	0	28,588,971	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet C
Part I
Date/Time Prepared:
2/28/2013 12:42 pm

		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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,416,152		4,416,152		30.00
31.00	03100	INTENSIVE CARE UNIT	787,019		787,019		31.00
40.00	04000	SUBPROVIDER - I/PF	3,078,085		3,078,085		40.00
43.00	04300	NURSERY	215,824		215,824		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,770,248	6,721,227	8,491,475	0.296898	50.00
51.00	05100	RECOVERY ROOM	176,864	784,169	961,033	0.168863	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	658,052	453,812	1,111,864	0.155647	52.00
53.00	05300	ANESTHESIOLOGY	303,890	1,233,752	1,537,642	0.343102	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,371,403	13,246,551	15,617,954	0.220586	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	147,094	2,768,912	2,916,006	0.155628	58.00
60.00	06000	LABORATORY	3,329,306	5,935,010	9,264,316	0.195788	60.00
64.00	06400	INTRAVENOUS THERAPY	699,695	312,671	1,012,366	0.342961	64.00
65.00	06500	RESPIRATORY THERAPY	2,138,115	569,264	2,707,379	0.204258	65.00
66.00	06600	PHYSICAL THERAPY	339,921	2,919,351	3,259,272	0.603762	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,177	371,719	412,896	0.385615	67.00
68.00	06800	SPEECH PATHOLOGY	7,070	100,579	107,649	1.806389	68.00
69.00	06900	ELECTROCARDIOLOGY	276,117	240,294	516,411	0.256402	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,432	13,692	24,124	1.608315	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	458,561	283,044	741,605	0.663882	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	409,079	329,506	738,585	0.523341	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,917,579	1,616,187	3,533,766	0.436387	73.00
75.00	07500	ASC (NON-DISTINCT PART)	425,143	4,551,262	4,976,405	0.465424	75.00
76.00	03160	STRESS TESTING	0	0	0	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	676,917	676,917	2.564471	76.01
76.97	07697	CARDIAC REHABILITATION	35,384	542,485	577,869	0.080048	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,601,632	5,831,460	7,433,092	0.274500	91.00
92.00	09200	OBSERVATION BEDS	47,081	402,676	449,757	1.115131	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	1,010,189	1,010,189		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	797,444	797,444		116.00
117.00	06950	HOMEMAKER	0	4,252	4,252		117.00
200.00		Subtotal (see instructions)	25,660,923	51,716,425	77,377,348		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	25,660,923	51,716,425	77,377,348		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet C
Part I
Date/Time Prepared:
2/28/2013 12:42 pm

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
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
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
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
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 CHRGD TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000			75.00
76.00	03160 STRESS TESTING	0.000000			76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.01
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS	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
117.00	06950 HOMEMAKER				117.00
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: 140110		Period: From 05/01/2012 To 09/30/2012		Worksheet D Part I Date/Time Prepared: 2/28/2013 12:42 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)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	253,891	0	253,891	3,182	79.79	30.00
31.00	03100	INTENSIVE CARE UNIT	33,947		33,947	348	97.55	31.00
40.00	04000	SUBPROVIDER - IPF	103,658	0	103,658	1,910	54.27	40.00
43.00	04300	NURSERY	2,264		2,264	287	7.89	43.00
200.00		Total (lines 30-199)	393,760		393,760	5,727		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140110		Period: From 05/01/2012 To 09/30/2012		Worksheet D Part I Date/Time Prepared: 2/28/2013 12:42 pm	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XVII I	Hospital	PPS	
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,464	116,813			30.00
31.00	03100	INTENSIVE CARE UNIT	246	23,997			31.00
40.00	04000	SUBPROVIDER - IPF	696	37,772			40.00
43.00	04300	NURSERY	0	0			43.00
200.00		Total (lines 30-199)	2,406	178,582			200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet D Part II Date/Time Prepared: 2/28/2013 12:42 pm
		Title XVIII		Hospital
				PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	197,388	8,491,475	0.023245	614,109	14,275	50.00
51.00	05100 RECOVERY ROOM	10,257	961,033	0.010673	83,634	893	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3,193	1,111,864	0.002872	0	0	52.00
53.00	05300 ANESTHESIOLOGY	15,249	1,537,642	0.009917	205,654	2,039	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	501,008	15,617,954	0.032079	1,273,423	40,850	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	159,893	2,916,006	0.054833	62,387	3,421	58.00
60.00	06000 LABORATORY	92,035	9,264,316	0.009934	1,716,413	17,051	60.00
64.00	06400 INTRAVENOUS THERAPY	7,104	1,012,366	0.007017	389,704	2,735	64.00
65.00	06500 RESPIRATORY THERAPY	28,445	2,707,379	0.010506	1,759,465	18,485	65.00
66.00	06600 PHYSICAL THERAPY	176,408	3,259,272	0.054125	219,423	11,876	66.00
67.00	06700 OCCUPATIONAL THERAPY	9,641	412,896	0.023350	29,948	699	67.00
68.00	06800 SPEECH PATHOLOGY	11,560	107,649	0.107386	3,892	418	68.00
69.00	06900 ELECTROCARDIOLOGY	3,887	516,411	0.007527	249,889	1,881	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	13,884	24,124	0.575526	1,956	1,126	70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	79,077	741,605	0.106630	285,004	30,390	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	17,264	738,585	0.023374	334,711	7,824	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	57,385	3,533,766	0.016239	1,118,216	18,159	73.00
75.00	07500 ASC (NON-DISTINCT PART)	194,528	4,976,405	0.039090	316,579	12,375	75.00
76.00	03160 STRESS TESTING	0	0	0.000000	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	241,439	676,917	0.356674	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	855	577,869	0.001480	3,610	5	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	105,389	7,433,092	0.014178	655,073	9,288	91.00
92.00	09200 OBSERVATION BEDS	36,863	449,757	0.081962	47,081	3,859	92.00
200.00	Total (lines 50-199)	1,962,752	67,068,383		9,370,171	197,649	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140110		Period: From 05/01/2012 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/28/2013 12:42 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	8,649	0	0	8,649	30.00
31.00	03100	INTENSIVE CARE UNIT	0	13,764	0	0	13,764	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	22,413	0	0	22,413	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140110		Period: From 05/01/2012 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/28/2013 12:42 pm	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PPS	
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,182	2.72	1,464	3,982		30.00
31.00	03100	INTENSIVE CARE UNIT	348	39.55	246	9,729		31.00
40.00	04000	SUBPROVIDER - IPF	1,910	0.00	696	0		40.00
43.00	04300	NURSERY	287	0.00	0	0		43.00
200.00		Total (lines 30-199)	5,727		2,406	13,711		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet D
Part IV
Date/Time Prepared:
2/28/2013 12:42 pm

Cost Center Description		Title XVIII				Hospital		PPS
		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	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00	
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	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00	
60.00	06000	LABORATORY	0	0	13,113	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	26,504	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 CHRGD TO PATIENTS	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00	
76.00	03160	STRESS TESTING	0	0	0	0	76.00	
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.01	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	38,408	0	91.00	
92.00	09200	OBSERVATION BEDS	0	0	1,256	0	92.00	
200.00		Total (lines 50-199)	0	0	79,281	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/28/2013 12:42 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	0	8,491,475	0.000000	0.000000	614,109	50.00
51.00	05100 RECOVERY ROOM	0	961,033	0.000000	0.000000	83,634	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,111,864	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	1,537,642	0.000000	0.000000	205,654	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	15,617,954	0.000000	0.000000	1,273,423	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2,916,006	0.000000	0.000000	62,387	58.00
60.00	06000 LABORATORY	13,113	9,264,316	0.001415	0.001415	1,716,413	60.00
64.00	06400 INTRAVENOUS THERAPY	0	1,012,366	0.000000	0.000000	389,704	64.00
65.00	06500 RESPIRATORY THERAPY	26,504	2,707,379	0.009790	0.009790	1,759,465	65.00
66.00	06600 PHYSICAL THERAPY	0	3,259,272	0.000000	0.000000	219,423	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	412,896	0.000000	0.000000	29,948	67.00
68.00	06800 SPEECH PATHOLOGY	0	107,649	0.000000	0.000000	3,892	68.00
69.00	06900 ELECTROCARDIOLOGY	0	516,411	0.000000	0.000000	249,889	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	24,124	0.000000	0.000000	1,956	70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	741,605	0.000000	0.000000	285,004	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	738,585	0.000000	0.000000	334,711	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3,533,766	0.000000	0.000000	1,118,216	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	4,976,405	0.000000	0.000000	316,579	75.00
76.00	03160 STRESS TESTING	0	0	0.000000	0.000000	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	676,917	0.000000	0.000000	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	577,869	0.000000	0.000000	3,610	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	38,408	7,433,092	0.005167	0.005167	655,073	91.00
92.00	09200 OBSERVATION BEDS	1,256	449,757	0.002793	0.002793	47,081	92.00
200.00	Total (lines 50-199)	79,281	67,068,383			9,370,171	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/28/2013 12:42 pm
Title XVIII		Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	2,351,410	0	50.00
51.00	05100 RECOVERY ROOM	0	209,026	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	771,826	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	3,961,817	0	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	861,419	0	58.00
60.00	06000 LABORATORY	2,429	327,626	464	60.00
64.00	06400 INTRAVENOUS THERAPY	0	283,924	0	64.00
65.00	06500 RESPIRATORY THERAPY	17,225	149,994	1,468	65.00
66.00	06600 PHYSICAL THERAPY	0	1,483	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	16,298	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	240,294	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	3,260	0	70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	51,227	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	310,326	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,225,949	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	2,040,551	0	75.00
76.00	03160 STRESS TESTING	0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	231,371	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	132,442	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	3,385	1,328,352	6,864	91.00
92.00	09200 OBSERVATION BEDS	131	224,762	628	92.00
200.00	Total (lines 50-199)	23,170	14,723,357	9,424	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/28/2013 12:42 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.296898	2,351,410	0	0	50.00
51.00	05100 RECOVERY ROOM	0.168863	209,026	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.155647	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.343102	771,826	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.220586	3,961,817	0	0	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.155628	861,419	0	0	58.00
60.00	06000 LABORATORY	0.195788	327,626	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.342961	283,924	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.204258	149,994	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.603762	1,483	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.385615	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	1.806389	16,298	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.256402	240,294	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.608315	3,260	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0.663882	51,227	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.523341	310,326	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.436387	1,225,949	0	1,818	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.465424	2,040,551	0	0	75.00
76.00	03160 STRESS TESTING	0.000000	0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2.564471	231,371	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.080048	132,442	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0.274500	1,328,352	0	0	91.00
92.00	09200 OBSERVATION BEDS	1.115131	224,762	0	0	92.00
200.00	Subtotal (see instructions)		14,723,357	0	1,818	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		14,723,357	0	1,818	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/28/2013 12:42 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			Hospital	PPS	
	PPS Services (see inst.)	Cost	Cost			
		Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	5.00	6.00	7.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	698,129	0	0	50.00
51.00	05100	RECOVERY ROOM	35,297	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	264,815	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	873,921	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	134,061	0	0	58.00
60.00	06000	LABORATORY	64,145	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	97,375	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	30,637	0	0	65.00
66.00	06600	PHYSICAL THERAPY	895	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	29,441	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	61,612	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,243	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	34,009	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	162,406	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	534,988	0	793	73.00
75.00	07500	ASC (NON-DISTINCT PART)	949,721	0	0	75.00
76.00	03160	STRESS TESTING	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	593,344	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	10,602	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	364,633	0	0	91.00
92.00	09200	OBSERVATION BEDS	250,639	0	0	92.00
200.00		Subtotal (see instructions)	5,195,913	0	793	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	5,195,913	0	793	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140110		Period: From 05/01/2012 To 09/30/2012		Worksheet D Part II Date/Time Prepared: 2/28/2013 12:42 pm	
		Component CCN: 14S110		Title XVIII		Subprovider - IPF	
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	197,388	8,491,475	0.023245	0	50.00
51.00	05100	RECOVERY ROOM	10,257	961,033	0.010673	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,193	1,111,864	0.002872	0	52.00
53.00	05300	ANESTHESIOLOGY	15,249	1,537,642	0.009917	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	501,008	15,617,954	0.032079	34,312	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	159,893	2,916,006	0.054833	13,645	58.00
60.00	06000	LABORATORY	92,035	9,264,316	0.009934	249,164	60.00
64.00	06400	INTRAVENOUS THERAPY	7,104	1,012,366	0.007017	5,548	64.00
65.00	06500	RESPIRATORY THERAPY	28,445	2,707,379	0.010506	35,971	65.00
66.00	06600	PHYSICAL THERAPY	176,408	3,259,272	0.054125	10,736	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,641	412,896	0.023350	884	67.00
68.00	06800	SPEECH PATHOLOGY	11,560	107,649	0.107386	3,178	68.00
69.00	06900	ELECTROCARDIOLOGY	3,887	516,411	0.007527	26,228	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,884	24,124	0.575526	652	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	79,077	741,605	0.106630	39,998	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	17,264	738,585	0.023374	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,385	3,533,766	0.016239	568,432	73.00
75.00	07500	ASC (NON-DISTINCT PART)	194,528	4,976,405	0.039090	0	75.00
76.00	03160	STRESS TESTING	0	0	0.000000	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	241,439	676,917	0.356674	0	76.01
76.97	07697	CARDIAC REHABILITATION	855	577,869	0.001480	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	105,389	7,433,092	0.014178	120,965	91.00
92.00	09200	OBSERVATION BEDS	0	449,757	0.000000	0	92.00
200.00		Total (lines 50-199)	1,925,889	67,068,383		1,109,713	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140110 Component CCN: 14S110	Period: From 05/01/2012 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/28/2013 12:42 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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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	0	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	13,113	0	13,113	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	26,504	0	26,504	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	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	38,408	0	38,408	91.00
92.00	09200	OBSERVATION BEDS	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	78,025	0	78,025	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140110 Component CCN: 14S110	Period: From 05/01/2012 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/28/2013 12:42 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	8,491,475	0.000000	0.000000	0	50.00
51.00	05100 RECOVERY ROOM	0	961,033	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,111,864	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	1,537,642	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	15,617,954	0.000000	0.000000	34,312	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2,916,006	0.000000	0.000000	13,645	58.00
60.00	06000 LABORATORY	13,113	9,264,316	0.001415	0.001415	249,164	60.00
64.00	06400 INTRAVENOUS THERAPY	0	1,012,366	0.000000	0.000000	5,548	64.00
65.00	06500 RESPIRATORY THERAPY	26,504	2,707,379	0.009790	0.009790	35,971	65.00
66.00	06600 PHYSICAL THERAPY	0	3,259,272	0.000000	0.000000	10,736	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	412,896	0.000000	0.000000	884	67.00
68.00	06800 SPEECH PATHOLOGY	0	107,649	0.000000	0.000000	3,178	68.00
69.00	06900 ELECTROCARDIOLOGY	0	516,411	0.000000	0.000000	26,228	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	24,124	0.000000	0.000000	652	70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	741,605	0.000000	0.000000	39,998	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	738,585	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3,533,766	0.000000	0.000000	568,432	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	4,976,405	0.000000	0.000000	0	75.00
76.00	03160 STRESS TESTING	0	0	0.000000	0.000000	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	676,917	0.000000	0.000000	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	577,869	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	38,408	7,433,092	0.005167	0.005167	120,965	91.00
92.00	09200 OBSERVATION BEDS	0	449,757	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	78,025	67,068,383			1,109,713	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/28/2013 12:42 pm
	Component CCN: 14S110	Title XVIII	Subprovider - IPF PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	51.00
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
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
60.00 06000 LABORATORY	353	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	352	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 CHRGD TO PATIENTS	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00 03160 STRESS TESTING	0	0	0	76.00
76.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
91.00 09100 EMERGENCY	625	0	0	91.00
92.00 09200 OBSERVATION BEDS	0	0	0	92.00
200.00 Total (lines 50-199)	1,330	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet D-1
		Title XVIII	Hospital	PPS
Cost Center Description		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,182	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,182	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)		2,720	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)		1,464	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)		3,454,307	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)		3,454,307	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		4,631,976	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		4,631,976	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.745752	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)		1,702.93	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)		3,454,307	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,085.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,589,289	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)		1,589,289	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet D-1 Date/Time Prepared: 2/28/2013 12:42 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	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	689,379	348	1,980.97	246	487,319	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,847,394	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,924,002	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)					154,521	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					220,819	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					375,340	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,548,662	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)					462	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,085.58	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					501,538	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140110		Period: From 05/01/2012 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/28/2013 12:42 pm	
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	253,891	3,454,307	0.073500	501,538	36,863	90.00
91.00	Nursing School cost	0	3,454,307	0.000000	501,538	0	91.00
92.00	Allied health cost	8,649	3,454,307	0.002504	501,538	1,256	92.00
93.00	All other Medical Education	0	3,454,307	0.000000	501,538	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet D-1
		Component CCN: 14S110		Date/Time Prepared: 2/28/2013 12:42 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)		1,910	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,910	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)		1,910	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)		696	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)		1,924,875	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,924,875	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,078,085	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,078,085	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.625348	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)		1,611.56	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,924,875	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,007.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		701,422	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)		701,422	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140110		Period: From 05/01/2012 To 09/30/2012		Worksheet D-1	
		Component CCN: 14S110				Date/Time Prepared: 2/28/2013 12:42 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	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					395,884		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,097,306		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)					37,772		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					22,797		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					60,569		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,036,737		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: 140110 Component CCN: 14S110		Period: From 05/01/2012 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/28/2013 12:42 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	103,658	1,924,875	0.053852	0	0	90.00
91.00	Nursing School cost	0	1,924,875	0.000000	0	0	91.00
92.00	Allied health cost	0	1,924,875	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,924,875	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/28/2013 12:42 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		1,460,802	30.00
31.00	03100	INTENSIVE CARE UNIT		533,328	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.296898	614,109	50.00
51.00	05100	RECOVERY ROOM	0.168863	83,634	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.155647	0	52.00
53.00	05300	ANESTHESIOLOGY	0.391762	205,654	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.220586	1,273,423	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.155628	62,387	58.00
60.00	06000	LABORATORY	0.195788	1,716,413	60.00
64.00	06400	INTRAVENOUS THERAPY	0.342961	389,704	64.00
65.00	06500	RESPIRATORY THERAPY	0.204258	1,759,465	65.00
66.00	06600	PHYSICAL THERAPY	0.604214	219,423	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.385615	29,948	67.00
68.00	06800	SPEECH PATHOLOGY	1.806389	3,892	68.00
69.00	06900	ELECTROCARDIOLOGY	0.256402	249,889	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.608315	1,956	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0.663882	285,004	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.523341	334,711	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.436387	1,118,216	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.465424	316,579	75.00
76.00	03160	STRESS TESTING	0.000000	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2.606167	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.080048	3,610	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.274500	655,073	91.00
92.00	09200	OBSERVATION BEDS	1.115131	47,081	92.00
200.00		Total (sum of lines 50-94 and 96-98)		9,370,171	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)		9,370,171	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140110 Component CCN: 14S110	Period: From 05/01/2012 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/28/2013 12:42 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		742,752		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.296898	0	0	50.00
51.00	05100 RECOVERY ROOM	0.168863	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.155647	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.391762	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.220586	34,312	7,569	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.155628	13,645	2,124	58.00
60.00	06000 LABORATORY	0.195788	249,164	48,783	60.00
64.00	06400 INTRAVENOUS THERAPY	0.342961	5,548	1,903	64.00
65.00	06500 RESPIRATORY THERAPY	0.204258	35,971	7,347	65.00
66.00	06600 PHYSICAL THERAPY	0.604214	10,736	6,487	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.385615	884	341	67.00
68.00	06800 SPEECH PATHOLOGY	1.806389	3,178	5,741	68.00
69.00	06900 ELECTROCARDIOLOGY	0.256402	26,228	6,725	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.608315	652	1,049	70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0.663882	39,998	26,554	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.523341	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.436387	568,432	248,056	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.465424	0	0	75.00
76.00	03160 STRESS TESTING	0.000000	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2.606167	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.080048	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.274500	120,965	33,205	91.00
92.00	09200 OBSERVATION BEDS	1.115131	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,109,713	395,884	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		1,109,713		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/28/2013 12:42 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		567,025	30.00
31.00	03100	INTENSIVE CARE UNIT		56,368	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY		118,816	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.296898	166,088	50.00
51.00	05100	RECOVERY ROOM	0.168863	18,798	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.155647	191,875	52.00
53.00	05300	ANESTHESIOLOGY	0.343102	74,778	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.220586	193,992	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.155628	12,595	58.00
60.00	06000	LABORATORY	0.195788	286,392	60.00
64.00	06400	INTRAVENOUS THERAPY	0.342961	93,952	64.00
65.00	06500	RESPIRATORY THERAPY	0.204258	127,243	65.00
66.00	06600	PHYSICAL THERAPY	0.603762	13,636	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.385615	884	67.00
68.00	06800	SPEECH PATHOLOGY	1.806389	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.256402	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.608315	0	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0.663882	64,807	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.523341	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.436387	172,451	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.465424	72,720	75.00
76.00	03160	STRESS TESTING	0.000000	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2.564471	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.080048	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.274500	126,798	91.00
92.00	09200	OBSERVATION BEDS	1.115131	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,617,009	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)		1,617,009	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet E Part A Date/Time Prepared: 2/28/2013 12:42 pm
		Title XVII I	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments			3,017,551 1.00
2.00	Outlier payments for discharges. (see instructions)			105,785 2.00
2.01	Outlier reconciliation amount			0 2.01
3.00	Managed Care Simulated Payments			0 3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			69.98 4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)			0.00 5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00 6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00 7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00 7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.			0.00 8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00 8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)			0.00 8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00 9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00 10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00 11.00
12.00	Current year allowable FTE (see instructions)			0.00 12.00
13.00	Total allowable FTE count for the prior year.			0.00 13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00 14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00 15.00
16.00	Adjustment for residents in initial years of the program			0.00 16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00 17.00
18.00	Adjusted rolling average FTE count			0.00 18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000 19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000 20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000 21.00
22.00	IME payment adjustment (see instructions)			0 22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).			0.00 23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00 24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00 25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000 26.00
27.00	IME payments adjustment. (see instructions)			0.000000 27.00
28.00	IME Adjustment (see instructions)			0 28.00
29.00	Total IME payment (sum of lines 22 and 28)			0 29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			1.81 30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)			17.42 31.00
32.00	Sum of lines 30 and 31			19.23 32.00
33.00	Allowable disproportionate share percentage (see instructions)			5.25 33.00
34.00	Disproportionate share adjustment (see instructions)			158,421 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)			3,281,757 47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)			3,282,457 48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)			3,282,282 49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)			255,224 50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)			0 51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).			0 52.00
53.00	Nursing and Allied Health Managed Care payment			7,955 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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet E Part A Date/Time Prepared: 2/28/2013 12:42 pm
		Title XVIII	Hospital	PPS
				1.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).			13,711 57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			23,170 58.00
59.00	Total (sum of amounts on lines 49 through 58)			3,582,342 59.00
60.00	Primary payer payments			0 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			3,582,342 61.00
62.00	Deductibles billed to program beneficiaries			413,848 62.00
63.00	Coinurance billed to program beneficiaries			3,468 63.00
64.00	Allowable bad debts (see instructions)			0 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			0 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			3,165,026 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			157,925 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)			3,322,951 71.00
72.00	Interim payments			3,534,517 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)			-211,566 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2			225,804 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: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/28/2013 12:42 pm
		Title XVII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		793	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,186,489	2.00
3.00	PPS payments		2,721,335	3.00
4.00	Outlier payment (see instructions)		281,792	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.722	5.00
6.00	Line 2 times line 5		3,744,645	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		80.20	7.00
8.00	Transitional corridor payment (see instructions)		630,290	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		9,424	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		793	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,818	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)		1,818	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		1,818	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,025	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)		793	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)		3,642,841	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)		659,304	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		2,984,330	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,984,330	30.00
31.00	Primary payer payments		1,196	31.00
32.00	Subtotal (line 30 minus line 31)		2,983,134	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)		2,983,134	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		2,983,134	40.00
41.00	Interim payments		3,451,129	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)		-467,995	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		76,636	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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
2/28/2013 12:42 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		3,457,561		2,343,289	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	09/30/2012	76,956	09/30/2012	1,044,337	3.01
3.02			0	09/30/2012	63,503	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)		76,956		1,107,840	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)		3,534,517		3,451,129	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		211,566		467,995	6.02
7.00	Total Medicare program liability (see instructions)		3,322,951		2,983,134	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: 140110

Period: From 05/01/2012

Worksheet E-1

Component CCN: 14S110

To 09/30/2012

Part I
Date/Time Prepared:
2/28/2013 12:42 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		485,834		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)		485,834		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		1,330		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		487,164		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140110 Component CCN: 14S110	Period: From 05/01/2012 To 09/30/2012	Worksheet E-3 Part II Date/Time Prepared: 2/28/2013 12:42 pm
		Title XVIIII	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)			581,929 1.00
2.00	Net IPF PPS Outlier Payments			8,054 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)			12.483660 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)			589,983 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)			589,983 16.00
17.00	Primary payer payments			1,265 17.00
18.00	Subtotal (line 16 less line 17).			588,718 18.00
19.00	Deductibles			102,884 19.00
20.00	Subtotal (line 18 minus line 19)			485,834 20.00
21.00	Coinsurance			0 21.00
22.00	Subtotal (line 20 minus line 21)			485,834 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)			485,834 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)			1,330 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)			487,164 31.00
32.00	Interim payments			485,834 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)			1,330 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			8,054 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

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

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet G

Date/Time Prepared:
2/28/2013 12:42 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	2,885,261	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	31,956,268	0	0	0	4.00
5.00	Other receivable	375,379	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-20,132,035	0	0	0	6.00
7.00	Inventory	1,604,449	0	0	0	7.00
8.00	Prepaid expenses	1,296,140	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	17,985,462	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,123,081	0	0	0	12.00
13.00	Land improvements	2,862,859	0	0	0	13.00
14.00	Accumulated depreciation	-2,278,133	0	0	0	14.00
15.00	Buildings	70,874,383	0	0	0	15.00
16.00	Accumulated depreciation	-56,637,510	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	34,281,977	0	0	0	19.00
20.00	Accumulated depreciation	-25,325,003	0	0	0	20.00
21.00	Automobiles and trucks	639,505	0	0	0	21.00
22.00	Accumulated depreciation	-575,927	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	4,700,719	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	31,665,951	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	19,595,596	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	19,595,596	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	69,247,009	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	7,227,291	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,614,567	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	6,072,382	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	17,914,240	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,914,240	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	51,332,769	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	51,332,769	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	69,247,009	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet G-1

Date/Time Prepared:
2/28/2013 12:42 pm

	General Fund		Special Purpose Fund			
	1.00	2.00	3.00	4.00		
	1.00		51,352,847			
2.00		-20,078			2.00	
3.00		51,332,769		0	3.00	
4.00	0		0		4.00	
5.00	0		0		5.00	
6.00	0		0		6.00	
7.00	0		0		7.00	
8.00	0		0		8.00	
9.00	0		0		9.00	
10.00		0		0	10.00	
11.00		51,332,769		0	11.00	
12.00	0		0		12.00	
13.00	0		0		13.00	
14.00	0		0		14.00	
15.00	0		0		15.00	
16.00	0		0		16.00	
17.00	0		0		17.00	
18.00		0		0	18.00	
19.00		51,332,769		0	19.00	

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet G-1

Date/Time Prepared:
2/28/2013 12:42 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140110

Period:
From 05/01/2012
To 09/30/2012

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/28/2013 12:42 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,631,976		4,631,976	1.00
2.00	SUBPROVIDER - IPF	3,078,085		3,078,085	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,710,061		7,710,061	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	787,019		787,019	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)	787,019		787,019	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,497,080		8,497,080	17.00
18.00	Ancillary services	15,515,130	43,670,404	59,185,534	18.00
19.00	Outpatient services	1,648,713	6,234,136	7,882,849	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,010,189	1,010,189	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	797,444	797,444	26.00
27.00	OTHER (SPECIFY)	982,777	3,708,916	4,691,693	27.00
27.01	STAT CHARGES	122,127	135,718	257,845	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	26,765,827	55,556,807	82,322,634	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,891,320		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		28,891,320		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet G-3 Date/Time Prepared: 2/28/2013 12:42 pm
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	82,322,634	1.00
2.00	Less contractual allowances and discounts on patients' accounts	54,441,733	2.00
3.00	Net patient revenues (line 1 minus line 2)	27,880,901	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,891,320	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,010,419	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	23,874	6.00
7.00	Income from investments	391,516	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	183,185	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	10	16.00
17.00	Revenue from sale of drugs to other than patients	4,423	17.00
18.00	Revenue from sale of medical records and abstracts	1,562	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	232,515	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER RENTAL INCOME	13,598	24.00
24.01	GAIN ON SALE OF ASSETS	8,788	24.01
25.00	Total other income (sum of lines 6-24)	859,471	25.00
26.00	Total (line 5 plus line 25)	-150,948	26.00
27.00	OTHER INCOME	-130,870	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-130,870	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-20,078	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140110

Period: From 05/01/2012

Worksheet H

HHA CCN: 147048

To 09/30/2012

Date/Time Prepared: 2/28/2013 12:42 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00			0		0	1.00
2.00			0		0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	126,231	0	339	365	6,020	5.00
HHA REIMBURSABLE SERVICES						
6.00	251,672	0	18,470	7,541	17,290	6.00
7.00	152,545	0	4,029	58,665	1,845	7.00
8.00	3,179	0	537	0	0	8.00
9.00	8,595	0	860	0	0	9.00
10.00	1,722	0	258	0	0	10.00
11.00	14,105	0	3,171	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
HHA NONREIMBURSABLE SERVICES						
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
22.00	0	0	0	0	0	22.00
23.00	0	0	0	0	0	23.00
24.00	558,049	0	27,664	66,571	25,155	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: 140110

Period:

Worksheet H

HHA CCN: 147048

From 05/01/2012

Date/Time Prepared:
2/28/2013 12:42 pm

To 09/30/2012

Home Health Agency I

PPS

	Total (sum of col. 1 thru 5)	Recl assifi cat ion	Recl assifi ed Tri al Bal ance (col. 6 + col. 7)	Adj ustments	Net Expenses for Al locati on (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	132,955	-1,338	131,617	-240	131,377 5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	294,973	0	294,973	0	294,973 6.00
7.00	Physical Therapy	217,084	0	217,084	0	217,084 7.00
8.00	Occupational Therapy	3,716	0	3,716	0	3,716 8.00
9.00	Speech Pathology	9,455	0	9,455	0	9,455 9.00
10.00	Medical Social Services	1,980	0	1,980	0	1,980 10.00
11.00	Home Health Aide	17,276	0	17,276	0	17,276 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)	677,439	-1,338	676,101	-240	675,861 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: 140110 HHA CCN: 147048	Period: From 05/01/2012 To 09/30/2012	Worksheet H-1 Part I Date/Time Prepared: 2/28/2013 12:42 pm PPS
			Home Health Agency I	

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
		Bldgs & Fixtures	Movable Equipment			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	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	131,377	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	294,973	0	0	0	6.00
7.00	Physical Therapy	217,084	0	0	0	7.00
8.00	Occupational Therapy	3,716	0	0	0	8.00
9.00	Speech Pathology	9,455	0	0	0	9.00
10.00	Medical Social Services	1,980	0	0	0	10.00
11.00	Home Health Aide	17,276	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	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	675,861	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 140110

Period: From 05/01/2012

Worksheet H-1

HHA CCN: 147048

To 09/30/2012

Part I
Date/Time Prepared:
2/28/2013 12:42 pm

Home Health
Agency I

PPS

		Subtotal (col s. 0-4) 4A.00	Administrative & General 5.00	Total (col s. 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	131,377	131,377		5.00
HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	294,973	71,173	366,146	6.00
7.00	Physical Therapy	217,084	52,380	269,464	7.00
8.00	Occupational Therapy	3,716	897	4,613	8.00
9.00	Speech Pathology	9,455	2,281	11,736	9.00
10.00	Medical Social Services	1,980	478	2,458	10.00
11.00	Home Health Aide	17,276	4,168	21,444	11.00
12.00	Supplies (see instructions)	0	0	0	12.00
13.00	Drugs	0	0	0	13.00
14.00	DME	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	17.00
18.00	Clinic	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	19.00
20.00	Day Care Program	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	21.00
22.00	Homemaker Service	0	0	0	22.00
23.00	All Others (specify)	0	0	0	23.00
24.00	Total (sum of lines 1-23)	675,861		675,861	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 140110

Period: From 05/01/2012

Worksheet H-1

HHA CCN: 147048

To 09/30/2012

Part II
Date/Time Prepared:
2/28/2013 12:42 pm

Home Health Agency I

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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	5A.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0	0	-131,377	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	-131,377	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 140110 HHA CCN: 147048	Period: From 05/01/2012 To 09/30/2012	Worksheet H-1 Part II Date/Time Prepared: 2/28/2013 12:42 pm PPS
			Home Health Agency I	

		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	544,484	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	294,973	6.00
7.00	Physical Therapy	217,084	7.00
8.00	Occupational Therapy	3,716	8.00
9.00	Speech Pathology	9,455	9.00
10.00	Medical Social Services	1,980	10.00
11.00	Home Health Aide	17,276	11.00
12.00	Supplies (see instructions)	0	12.00
13.00	Drugs	0	13.00
14.00	DME	0	14.00
HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	15.00
16.00	Respiratory Therapy	0	16.00
17.00	Private Duty Nursing	0	17.00
18.00	Clinic	0	18.00
19.00	Health Promotion Activities	0	19.00
20.00	Day Care Program	0	20.00
21.00	Home Delivered Meals Program	0	21.00
22.00	Homemaker Service	0	22.00
23.00	All Others (specify)	0	23.00
24.00	Total (sum of lines 1-23)	544,484	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	131,377	25.00
26.00	Unit Cost Multiplier	0.241287	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140110

Period: From 05/01/2012

Worksheet H-2

HHA CCN: 147048

To 09/30/2012

Part I
Date/Time Prepared:
2/28/2013 12:42 pm

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
	0			4.00	4A	
1.00 Administrative and General	0	0	31,170	46,669	77,839	1.00
2.00 Skilled Nursing Care	366,146	0	0	98,141	464,287	2.00
3.00 Physical Therapy	269,464	0	0	59,486	328,950	3.00
4.00 Occupational Therapy	4,613	0	0	1,240	5,853	4.00
5.00 Speech Pathology	11,736	0	0	3,352	15,088	5.00
6.00 Medical Social Services	2,458	0	0	672	3,130	6.00
7.00 Home Health Aide	21,444	0	0	5,500	26,944	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)	675,861	0	31,170	215,060	922,091	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: 140110

Period:

Worksheet H-2

HHA CCN: 147048

From 05/01/2012
To 09/30/2012

Part I
Date/Time Prepared:
2/28/2013 12:42 pm

Home Health
Agency I

PPS

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	20,644	0	0	19,992	0	1.00
2.00	Skilled Nursing Care	123,139	0	0	0	0	2.00
3.00	Physical Therapy	87,244	0	0	0	0	3.00
4.00	Occupational Therapy	1,552	0	0	0	0	4.00
5.00	Speech Pathology	4,002	0	0	0	0	5.00
6.00	Medical Social Services	830	0	0	0	0	6.00
7.00	Home Health Aide	7,146	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)	244,557	0	0	19,992	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: 140110

Period: From 05/01/2012

Worksheet H-2

HHA CCN: 147048

To 09/30/2012

Part I
Date/Time Prepared:
2/28/2013 12:42 pm

Home Health
Agency I

PPS

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	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: 140110

Period:

Worksheet H-2

HHA CCN: 147048

From 05/01/2012

Part I

To 09/30/2012

Date/Time Prepared:

Home Health Agency I

PPS

Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		17.00	19.00	23.00	24.00	25.00	
1.00	Administrative and General	0	0	0	118,475	0	1.00
2.00	Skilled Nursing Care	0	0	0	587,426	0	2.00
3.00	Physical Therapy	0	0	0	416,194	0	3.00
4.00	Occupational Therapy	0	0	0	7,405	0	4.00
5.00	Speech Pathology	0	0	0	19,090	0	5.00
6.00	Medical Social Services	0	0	0	3,960	0	6.00
7.00	Home Health Aide	0	0	0	34,090	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	1,186,640	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: 140110	Period: From 05/01/2012	Worksheet H-2
		HHA CCN: 147048	To 09/30/2012	Part I
				Date/Time Prepared: 2/28/2013 12:42 pm
			Home Health Agency I	PPS

Cost Center Description		Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		26.00	27.00	28.00	
1.00	Administrative and General	118,475			1.00
2.00	Skilled Nursing Care	587,426	65,155	652,581	2.00
3.00	Physical Therapy	416,194	46,162	462,356	3.00
4.00	Occupational Therapy	7,405	821	8,226	4.00
5.00	Speech Pathology	19,090	2,117	21,207	5.00
6.00	Medical Social Services	3,960	439	4,399	6.00
7.00	Home Health Aide	34,090	3,781	37,871	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) (2)	1,186,640	118,475	1,186,640	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.		0.110915		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: 140110
HHA CCN: 147048

Period:
From 05/01/2012
To 09/30/2012

Worksheet H-2
Part II
Date/Time Prepared:
2/28/2013 12:42 pm
PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
1.00 Administrative and General	0	33,167	119,677	0	77,839	1.00
2.00 Skilled Nursing Care	0	0	251,672	0	464,287	2.00
3.00 Physical Therapy	0	0	152,545	0	328,950	3.00
4.00 Occupational Therapy	0	0	3,179	0	5,853	4.00
5.00 Speech Pathology	0	0	8,595	0	15,088	5.00
6.00 Medical Social Services	0	0	1,722	0	3,130	6.00
7.00 Home Health Aide	0	0	14,105	0	26,944	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)	0	33,167	551,495		922,091	20.00
21.00 Total cost to be allocated	0	31,170	215,060		244,557	21.00
22.00 Unit cost multiplier	0.000000	0.939790	0.389958		0.265220	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet H-2 Part II
	HHA CCN: 147048		Date/Time Prepared: 2/28/2013 12:42 pm
		Home Health Agency I	PPS

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	
	7.00	8.00	9.00	10.00	11.00	
1.00 Administrative and General	0	0	616	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)	0	0	616	0	0	20.00
21.00 Total cost to be allocated	0	0	19,992	0	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	32.454545	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet H-2 Part II
	HHA CCN: 147048		Date/Time Prepared: 2/28/2013 12:42 pm
		Home Health Agency I	PPS

Cost Center Description	NURSING ADMINISTRATION (HOURS SUPERVISED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
	13.00	14.00	15.00	16.00	17.00	
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)	0	0	0	0	0	20.00
21.00 Total cost to be allocated	0	0	0	0	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet H-2 Part II
	HHA CCN: 147048	Home Health Agency I	Date/Time Prepared: 2/28/2013 12:42 pm PPS

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

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 140110 HHA CCN: 147048	Period: From 05/01/2012 To 09/30/2012	Worksheet H-3 Parts I-III Date/Time Prepared: 2/28/2013 12:42 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 (col. 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	652,581		652,581	2,431	1.00
2.00	Physical Therapy	3.00	462,356	0	462,356	1,815	2.00
3.00	Occupational Therapy	4.00	8,226	0	8,226	50	3.00
4.00	Speech Pathology	5.00	21,207	0	21,207	74	4.00
5.00	Medical Social Services	6.00	4,399		4,399	27	5.00
6.00	Home Health Aide	7.00	37,871		37,871	370	6.00
7.00	Total (sum of lines 1-6)		1,186,640	0	1,186,640	4,767	7.00
Program Visits							
Cost Center Description		Cost Limits	CBSA No. (1)	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	898	468		8.00
9.00	Physical Therapy		99914	701	513		9.00
10.00	Occupational Therapy		99914	9	9		10.00
11.00	Speech Pathology		99914	37	1		11.00
12.00	Medical Social Services		99914	11	6		12.00
13.00	Home Health Aide		99914	123	134		13.00
14.00	Total (sum of lines 8-13)			1,779	1,131		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 (col. 1 + 2)	Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00
Cost Center Description			From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	
			0	1.00	2.00	3.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy		66.00	0.603762	0	0	1.00
2.00	Occupational Therapy		67.00	0.385615	0	0	2.00
3.00	Speech Pathology		68.00	1.806389	0	0	3.00
4.00	Cost of Medical Supplies		71.00	0.663882	0	0	4.00
5.00	Cost of Drugs		73.00	0.436387	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 140110 HHA CCN: 147048		Period: From 05/01/2012 To 09/30/2012		Worksheet H-3 Parts I-III Date/Time Prepared: 2/28/2013 12:42 pm	
		Title XVII		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	268.44	898	468			1.00
2.00	Physical Therapy	254.74	701	513			2.00
3.00	Occupational Therapy	164.52	9	9			3.00
4.00	Speech Pathology	286.58	37	1			4.00
5.00	Medical Social Services	162.93	11	6			5.00
6.00	Home Health Aide	102.35	123	134			6.00
7.00	Total (sum of lines 1-6)		1,779	1,131			7.00
Cost Center Description		5.00	6.00	7.00	8.00	9.00	
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00
Cost Center Description		5.00	6.00	7.00	8.00		
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			8.00
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0.000000					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: 140110 HHA CCN: 147048		Period: From 05/01/2012 To 09/30/2012		Worksheet H-3 Parts I-11 Date/Time Prepared: 2/28/2013 12:42 pm	
		Title XVII I		Home Health Agency I		PPS	
Cost Center Description	Cost of Services			Total Program Cost (sum of col.s. 9-10)			
	Part A	Part B					
		Not Subject to Deductibles & Co-insurance	Subject to Deductibles & Co-insurance				
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	241,059	125,630		366,689		1.00
2.00	Physical Therapy	178,573	130,682		309,255		2.00
3.00	Occupational Therapy	1,481	1,481		2,962		3.00
4.00	Speech Pathology	10,603	287		10,890		4.00
5.00	Medical Social Services	1,792	978		2,770		5.00
6.00	Home Health Aide	12,589	13,715		26,304		6.00
7.00	Total (sum of lines 1-6)	446,097	272,773		718,870		7.00
Cost Center Description		10.00	11.00	12.00			
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00
Cost Center Description	Cost of Services			Total Program Cost (sum of col.s. 9-10)			
	Part A	Part B					
		Not Subject to Deductibles & Co-insurance	Subject to Deductibles & Co-insurance				
9.00	10.00	11.00	12.00				
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies			0			15.00
16.00	Cost of Drugs				0		16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 140110 HHA CCN: 147048	Period: From 05/01/2012 To 09/30/2012	Worksheet H-4 Part I-II Date/Time Prepared: 2/28/2013 12:42 pm	
		Title XVII	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	0	0	0	2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00
			Part A Services	Part B Services	
			1.00	2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)		0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		299,088	212,543	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		7,526	5,502	13.00
14.00	Total PPS Reimbursement - PEP Episodes		2,976	2,515	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0	16.00
17.00	Total Other Payments		0	0	17.00
18.00	DME Payments		0	0	18.00
19.00	Oxygen Payments		0	0	19.00
20.00	Prosthetic and Orthotic Payments		0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		309,590	220,560	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		309,590	220,560	24.00
25.00	Coinurance billed to program patients (from your records)		0	0	25.00
26.00	Net cost (line 24 minus line 25)		309,590	220,560	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)		309,590	220,560	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)		309,590	220,560	31.00
32.00	Interim payments (see instructions)		309,590	220,559	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	1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	0	35.00

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

Provider CCN: 140110
HHA CCN: 147048

Period:
From 05/01/2012
To 09/30/2012

Worksheet H-5
Date/Time Prepared:
2/28/2013 12:42 pm
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		309,590		220,559	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)		309,590		220,559	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		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		309,590		220,560	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140110

Period: From 05/01/2012

Worksheet K

Hospice CCN: 141570

To 09/30/2012

Date/Time Prepared: 2/28/2013 12:42 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	41,908	0	6,468	0	7,881	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	7,292	0	9.00
10.00	Nursing Care	37,465	0	0	0	13,907	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	293	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	16,204	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	1,000	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)	79,373	0	6,468	8,292	38,285	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140110

Period: From 05/01/2012

Worksheet K

Hospice CCN: 141570

To 09/30/2012

Date/Time Prepared: 2/28/2013 12:42 pm

		Hospice I				
	Total (col. 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	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	5.00
6.00	Administrative and General	56,257	354	56,611	-15	56,596
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	7,292	0	7,292	-7,292	0
10.00	Nursing Care	51,372	0	51,372	0	51,372
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0
12.00	Physical Therapy	0	0	0	0	0
13.00	Occupational Therapy	0	0	0	0	0
14.00	Speech/ Language Pathology	0	0	0	0	0
15.00	Medical Social Services	0	0	0	0	0
16.00	Spiritual Counseling	0	0	0	0	0
17.00	Dietary Counseling	293	0	293	0	293
18.00	Counseling - Other	0	0	0	0	0
19.00	Home Health Aide and Homemaker	0	0	0	0	0
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0
21.00	Other	0	0	0	0	0
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	16,204	0	16,204	0	16,204
23.00	Analgesics	0	0	0	0	0
24.00	Sedatives / Hypnotics	0	0	0	0	0
25.00	Other - Specify	0	0	0	0	0
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0
27.00	Patient Transportation	1,000	0	1,000	0	1,000
28.00	Imaging Services	0	0	0	0	0
29.00	Labs and Diagnostics	0	0	0	0	0
30.00	Medical Supplies	0	0	0	0	0
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0
32.00	Radiation Therapy	0	0	0	0	0
33.00	Chemotherapy	0	0	0	0	0
34.00	Other	0	0	0	0	0
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0
36.00	Volunteer Program Costs	0	0	0	0	0
37.00	Fundraising	0	0	0	0	0
38.00	Other Program Costs	0	0	0	0	0
39.00	Total (sum of lines 1 thru 38)	132,418	354	132,772	-7,307	125,465

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140110

Period:

Worksheet K-1

Hospice CCN: 141570

From 05/01/2012
To 09/30/2012

Date/Time Prepared:
2/28/2013 12:42 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	41,908	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	37,465	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	41,908	0	0	0	37,465	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140110

Period: From 05/01/2012

Worksheet K-1

Hospice CCN: 141570

To 09/30/2012

Date/Time Prepared: 2/28/2013 12:42 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	0	41,908	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	37,465	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	0	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	79,373	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet K-3
		Hospice CCN: 141570		Date/Time Prepared: 2/28/2013 12:42 pm

		Hospice I				
		Administrator	Director	Social Services	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	3.00
4.00	Transportation - Staff	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					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	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES	Provider CCN: 140110 Hospice CCN: 141570	Period: From 05/01/2012 To 09/30/2012	Worksheet K-3 Date/Time Prepared: 2/28/2013 12:42 pm
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		Total Therapists	Aides	All-Other	Hospice I Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	0	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	7,292	7,292	9.00
10.00	Nursing Care		0	0	0	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	0	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	1,000	1,000	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	8,292	8,292	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140110

Period: From 05/01/2012

Worksheet K-4

Hospice CCN: 141570

To 09/30/2012

Part I
Date/Time Prepared:
2/28/2013 12:42 pm

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
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	56,596	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	51,372	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	293	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	16,204	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	1,000	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)	125,465	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140110

Period: From 05/01/2012

Worksheet K-4

Hospice CCN: 141570

To 09/30/2012

Part I
Date/Time Prepared:
2/28/2013 12:42 pm

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	Hospice I 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	56,596	56,596		6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	0	51,372	42,217	93,589	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	293	241	534	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	16,204	13,316	29,520	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	1,000	822	1,822	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	125,465		125,465	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140110

Period:

Worksheet K-4

Hospice CCN: 141570

From 05/01/2012
To 09/30/2012

Part II
Date/Time Prepared:
2/28/2013 12:42 pm

		CAPITAL RELATED COST		PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT (\$ VALUE)				
		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: 140110	Period:	Worksheet K-4
	Hospice CCN: 141570	From 05/01/2012 To 09/30/2012	Part II Date/Time Prepared: 2/28/2013 12:42 pm
			Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-56,596	68,869	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	0	9.00
10.00	Nursing Care	0	51,372	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	0	12.00
13.00	Occupational Therapy	0	0	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	0	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	293	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	16,204	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	1,000	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	0	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)		56,596	39.00
40.00	Unit Cost Multiplier		0.821792	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140110

Period: From 05/01/2012

Worksheet K-5

Hospice CCN: 141570

To 09/30/2012

Part I
Date/Time Prepared:
2/28/2013 12:42 pm

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
	0			4.00	4A	
1.00 Administrative and General		0	485	16,342	16,827	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	93,589	0	0	14,610	108,199	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	534	0	0	0	534	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	29,520	0	0	0	29,520	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	1,822	0	0	0	1,822	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)	125,465	0	485	30,952	156,902	34.00
35.00 Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140110

Period:

Worksheet K-5

Hospice CCN: 141570

From 05/01/2012
To 09/30/2012

Part I
Date/Time Prepared:
2/28/2013 12:42 pm

Cost Center Description		Hospice I					
		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
1.00	Administrative and General	4,463	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	28,697	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	142	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	7,829	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	483	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)	41,614	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: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet K-5 Part I Date/Time Prepared: 2/28/2013 12:42 pm
		Hospice CCN: 141570	Hospice I	

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	0	0	0	0	0	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	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: 140110	Period: From 05/01/2012	Worksheet K-5 Part I
		Hospice CCN: 141570	To 09/30/2012	Date/Time Prepared: 2/28/2013 12:42 pm

Cost Center Description		Hospice I				
		SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	PARAMED ED PRGM	Subtotal (col s. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments
		17.00	19.00	23.00	24.00	25.00
1.00	Administrative and General	0	0	0	21,290	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	136,896	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	676	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	37,349	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	2,305	22.00
23.00	Imaging Services	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	28.00
29.00	Other	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	198,516	34.00
35.00	Unit Cost Multiplier (see instructions)					35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		Provider CCN: 140110	Period: From 05/01/2012	Worksheet K-5 Part I
		Hospice CCN: 141570	To 09/30/2012	Date/Time Prepared: 2/28/2013 12:42 pm
			Hospice I	

Cost Center Description		Subtotal (col s. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (col s. 26 ± 27)	
		26.00	27.00	28.00	
1.00	Administrative and General				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	136,896	16,445	153,341	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	676	81	757	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	37,349	4,487	41,836	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	2,305	277	2,582	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)	198,516		198,516	34.00
35.00	Unit Cost Multiplier (see instructions)		0.120129		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140110
Hospice CCN: 141570

Period:
From 05/01/2012
To 09/30/2012

Worksheet K-5
Part II
Date/Time Prepared:
2/28/2013 12:42 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
1.00	Administrative and General	0	485	41,908	0	16,827	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	37,465	0	108,199	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	534	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	29,520	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	1,822	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	485	79,373		156,902	34.00
35.00	Total cost to be allocated	0	485	30,952		41,614	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	1.000000	0.389956		0.265223	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140110

Period:

Worksheet K-5

Hospice CCN: 141570

From 05/01/2012
To 09/30/2012

Part II
Date/Time Prepared:
2/28/2013 12:42 pm

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140110
Hospice CCN: 141570

Period:
From 05/01/2012
To 09/30/2012

Worksheet K-5
Part II
Date/Time Prepared:
2/28/2013 12:42 pm

Cost Center Description	Hospice I						
	NURSING ADMINISTRATIVE (HOURS SUPERVISED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
	13.00	14.00	15.00	16.00	17.00		
1.00 Administrative and General	0	0	0	0	0	0	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	0	4.00
5.00 Nursing Care	0	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	0	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	0	0	0	0	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	0	0	0	0	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	0	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	0	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	0	0	0	0	0	34.00
35.00 Total cost to be allocated	0	0	0	0	0	0	35.00
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140110
Hospice CCN: 141570

Period:
From 05/01/2012
To 09/30/2012

Worksheet K-5
Part II
Date/Time Prepared:
2/28/2013 12:42 pm

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

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 140110 Hospice CCN: 141570	Period: From 05/01/2012 To 09/30/2012	Worksheet K-5 Part III Date/Time Prepared: 2/28/2013 12:42 pm		
Cost Center Description		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2) 3.00	
		0	1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.604214	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.385615	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	1.806389	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.436387	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.195788	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHRGD TO PATIENTS	71.00	0.663882	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	STRESS TESTING	76.00	0.000000	0	0	10.00
10.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01	2.606167	0	0	10.01
10.97	CARDIAC REHABILITATION	76.97	0.080048	0	0	10.97
11.00	Totals (sum of lines 1-10)					11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 140110

Period:

Worksheet K-6

Hospice CCN: 141570

From 05/01/2012
To 09/30/2012

Date/Time Prepared:
2/28/2013 12:42 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				198,516	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				1,672	2.00
3.00	Average cost per diem (line 1 divided by line 2)				118.73	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	1,364				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	161,948				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		83			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		9,855			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	255				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	30,276				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			225		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			26,714		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140110	Period: From 05/01/2012 To 09/30/2012	Worksheet L Parts I-III Date/Time Prepared: 2/28/2013 12:42 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		244,041	1.00
2.00	Capital DRG outlier payments		11,183	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		20.05	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		255,224	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