

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: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet S Parts I-III Date/Time Prepared: 2/27/2013 9:29 am
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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: 2/27/2013	Time: 9:29 am
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 ST. MARGARET'S HOSPITAL (140143) for the cost reporting period beginning 10/01/2011 and ending 09/30/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title XVIII		HIT	Title XIX	
	Title V	Part A			
	1.00	2.00	3.00	4.00	5.00
PART III - SETTLEMENT SUMMARY					
1.00 Hospital	0	-217,936	-333,881	0	0
2.00 Subprovider - IPF	0	0	0	0	0
3.00 Subprovider - IRF	0	0	0	0	0
4.00 SUBPROVIDER I	0	0	0	0	0
5.00 Swing bed - SNF	0	425	0	0	0
6.00 Swing bed - NF	0	0	0	0	0
7.00 SKILLED NURSING FACILITY	0	0	0	0	0
8.00 NURSING FACILITY	0	0	0	0	0
9.00 HOME HEALTH AGENCY I	0	0	0	0	0
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0
12.00 CMHC I	0	0	0	0	0
200.00 Total	0	-217,511	-333,881	0	0

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: 140143			Period: From 10/01/2011 To 09/30/2012		Worksheet S-2 Part I Date/Time Prepared: 2/27/2013 9:29 am						
1.00		2.00		3.00		4.00							
Hospital and Hospital Health Care Complex Address:													
1.00	Street: 600 EAST FIRST ST			PO Box:						1.00			
2.00	City: SPRING VALLEY			State: IL		Zip Code: 61362		County: BUREAU		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			
Hospital and Hospital-Based Component Identification:													
3.00	Hospital		ST. MARGARET'S HOSPITAL	140143	99914	1	07/01/1966	N	P	P	3.00		
4.00	Subprovider - IPF										4.00		
5.00	Subprovider - IRF										5.00		
6.00	Subprovider - (Other)										6.00		
7.00	Swing Beds - SNF		ST. MARGARET'S HOSPITAL	14U143	99914		06/23/2003	N	P	N	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										12.00		
13.00	Separately Certified ASC										13.00		
14.00	Hospital-Based Hospice		ST. MARGARET'S HOSPITAL	141595	99914		07/07/1998				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)						10/01/2011		09/30/2012		20.00		
21.00	Type of Control (see instructions)						1				21.00		
Inpatient PPS Information													
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						2		N		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.						0	0	0	0	0	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: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/27/2013 9:29 am		
		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.	10/01/2011	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.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 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		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, 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: 140143

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

Worksheet S-2
Part I
Date/Time Prepared:
2/27/2013 9:29 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/27/2013 9:29 am		
		1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost 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	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				
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				
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.					
		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		
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		
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		
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		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		
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		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	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.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/27/2013 9:29 am
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	534,666	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.		N	
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	35H002
		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: SISTERS MARY OF THE PRESENTATION HC	Contractor's Name: NORIDIAN ADMIN SVC		Contractor's Number: 03001
142.00	Street: 1202 PAGE DR SW PO BOX 10007	PO Box:		
143.00	City: FARGO	State: ND		Zip Code: 58106-0007
			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
		1.00	2.00	3.00
				Title XIX
				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
156.00	Subprovider - IPF	N	N	N
157.00	Subprovider - IRF	N	N	N
158.00	SUBPROVIDER			
159.00	SNF	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N
161.00	CMHC		N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140143			Period: From 10/01/2011 To 09/30/2012		Worksheet S-2 Part I Date/Time Prepared: 2/27/2013 9:29 am	
							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)							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: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part II Date/Time Prepared: 2/27/2013 9:29 am
		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N	
			1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
		Description	Y/N	Date
		0	1.00	2.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/28/2013	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	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:	Y		20.00
		PIP PAYMENTS WERE ENTERED AS PAYMENT		

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part II Date/Time Prepared: 2/27/2013 9:29 am
		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.			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.	DON	TROGLIO	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. MARGARET'S HOSPITAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-664-1328	DTROGLIO@ABOUTSMG.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	01/28/2013	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR OF ACCOUNTING		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: 140143

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

Worksheet S-3
Part I
Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	63	23,058	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)		63	23,058	0.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,196	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)		69	25,254	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		69				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: 140143

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

Worksheet S-3
Part I
Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	4,503	556	6,830		1.00
2.00 HMO		342	0			2.00
3.00 HMO IPF Subprovider		0	0			3.00
4.00 HMO IRF Subprovider		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	459	0	490		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	4,962	556	7,320		7.00
8.00 INTENSIVE CARE UNIT	0	525	47	839		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		275	577		13.00
14.00 Total (see instructions)	0	5,487	878	8,736		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE		0	0	0		24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		188	1,581		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				35		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			41	95		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140143

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

Worksheet S-3
Part I
Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	1,316	1.00
2.00 HMO					0	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	505.04	0.00	0	1,316	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00	6.43	0.00			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	511.47	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: 140143

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

Worksheet S-3
Part I
Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	422	2,371		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)	422	2,371		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140143		Period: From 10/01/2011 To 09/30/2012		Worksheet S-3 Part II Date/Time Prepared: 2/27/2013 9:29 am	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	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	28,323,809	0	28,323,809	1,059,366.03	26.74	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		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	6,590,229	6,590,229	38,327.50	171.95	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)		10,847,319	-9,667,284	1,180,035	49,982.59	23.61	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		422,844	0	422,844	6,315.95	66.95	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		723,249	0	723,249	4,799.53	150.69	13.00
14.00	Home office salaries & wage-related costs		1,188,580	0	1,188,580	8,835.00	134.53	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		5,326,397	0	5,326,397			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0			18.00
19.00	Excluded areas		267,332	0	267,332			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		200,729	0	200,729			23.00
24.00	Wage-related costs (RHC/FOHC)		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	179,816	0	179,816	7,578.00	23.73	26.00
27.00	Administrative & General	5.00	2,153,138	-110,262	2,042,876	102,177.03	19.99	27.00
28.00	Administrative & General under contract (see inst.)		177,939	0	177,939	695.20	255.95	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	367,467	0	367,467	21,423.20	17.15	30.00
31.00	Laundry & Linen Service	8.00	0	28,409	28,409	2,865.25	9.92	31.00
32.00	Housekeeping	9.00	393,303	-28,409	364,894	35,157.95	10.38	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	778,737	-515,290	263,447	18,581.23	14.18	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	515,290	515,290	36,344.07	14.18	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	759,886	0	759,886	23,379.53	32.50	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	1,226,009	0	1,226,009	56,552.16	21.68	41.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140143

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

Worksheet S-3
Part II
Date/Time Prepared:
2/27/2013 9:29 am

		Worksheet A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140143

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

Worksheet S-3
Part III
Date/Time Prepared:
2/27/2013 9:29 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	28,501,748	-6,590,229	21,911,519	1,021,733.73	21.45	1.00
2.00	Excluded area salaries (see instructions)	10,847,319	-9,667,284	1,180,035	49,982.59	23.61	2.00
3.00	Subtotal salaries (line 1 minus line 2)	17,654,429	3,077,055	20,731,484	971,751.14	21.33	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,334,673	0	2,334,673	19,950.48	117.02	4.00
5.00	Subtotal wage-related costs (see inst.)	5,326,397	0	5,326,397	0.00	25.69	5.00
6.00	Total (sum of lines 3 thru 5)	25,315,499	3,077,055	28,392,554	991,701.62	28.63	6.00
7.00	Total overhead cost (see instructions)	6,036,295	-110,262	5,926,033	304,753.62	19.45	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet S-3 Part IV Date/Time Prepared: 2/27/2013 9:29 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	679,305	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)	2,476,920	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	165,423	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	22,359	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	2,844	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	127,607	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	438,604	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	1,386,099	17.00
18.00	Medicare Taxes - Employers Portion Only	401,872	18.00
19.00	Unemployment Insurance	70,195	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	23,229	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,794,457	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140143

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

Worksheet S-3
Part V
Date/Time Prepared:
2/27/2013 9:29 am

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140143

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

Worksheet S-7

Date/Time Prepared:
2/27/2013 9:29 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	Y		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	06/23/2003	2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00	
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	0	0	0	7.00
8.00	RHL	0	0	0	8.00
9.00	RMX	0	10	10	9.00
10.00	RML	0	3	3	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	0	0	0	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	0	0	0	14.00
15.00	RVC	0	0	0	15.00
16.00	RVB	0	0	0	16.00
17.00	RVA	0	0	0	17.00
18.00	RHC	0	0	0	18.00
19.00	RHB	0	0	0	19.00
20.00	RHA	0	8	8	20.00
21.00	RMC	0	57	57	21.00
22.00	RMB	0	39	39	22.00
23.00	RMA	0	47	47	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	0	44	44	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	0	29	29	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	0	10	10	32.00
33.00	HC2	0	3	3	33.00
34.00	HC1	0	1	1	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	0	7	7	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	6	6	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	0	44	44	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	0	1	1	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	0	0	0	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	0	39	39	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	0	26	26	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	0	22	22	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	0	44	44	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	0	14	14	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140143

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

Worksheet S-7

Date/Time Prepared:
2/27/2013 9:29 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	2	2	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	3	3	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	459	459	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).		99914	99914	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

HOSPITAL IDENTIFICATION DATA		Provider CCN: 140143		Period:		Worksheet S-9	
		Component CCN: 141595		From 10/01/2011 To 09/30/2012		Parts I & II Date/Time Prepared: 2/27/2013 9:29 am	
		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	
2.00	Routine Home Care	2,426	2	0	0	5	
3.00	Inpatient Respite Care	13	0	0	0	1	
4.00	General Inpatient Care	3,693	0	0	0	0	
5.00	Total Hospice Days	6,132	2	0	0	6	
Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	75	1	0	0	3	
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00		7.00	
8.00	Average Length of Stay (line 5/line 6)	81.76	2.00	0.00	0.00	2.00	
9.00	Unduplicated Census Count	64	1	0	0	3	

HOSPITAL IDENTIFICATION DATA		Provider CCN: 140143 Component CCN: 141595	Period: From 10/01/2011 To 09/30/2012	Worksheet S-9 Parts I & II Date/Time Prepared: 2/27/2013 9:29 am
		Hospice I		

		Unduplicated Days	
		Total (sum of cols. 1, 2 & 5)	
		6.00	
PART I - ENROLLMENT DAYS			
1.00	Continuous Home Care	0	1.00
2.00	Routine Home Care	2,433	2.00
3.00	Inpatient Respite Care	14	3.00
4.00	General Inpatient Care	3,693	4.00
5.00	Total Hospice Days	6,140	5.00
Part II - CENSUS DATA			
6.00	Number of Patients Receiving Hospice Care	79	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)	77.72	8.00
9.00	Unduplicated Census Count	68	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet S-10 Date/Time Prepared: 2/27/2013 9:29 am	
				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)		0.353395	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,511,581	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		14,743,980	6.00	
7.00	Medicaid cost (line 1 times line 6)		5,210,449	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		3,698,868	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		185,146	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		3,698,868	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	1,572,001	204,470	1,776,471	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	555,537	72,259	627,796	21.00
22.00	Partial payment by patients approved for charity care	192,977	47,106	240,083	22.00
23.00	Cost of charity care (line 21 minus line 22)	362,560	25,153	387,713	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)		3,976,169	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		213,624	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		3,762,545	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		1,329,665	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		1,717,378	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,416,246	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140143

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

Worksheet A
Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		1,626,587	1,626,587	-237,134	1,389,453	1.00
1.01	00101		128,170	128,170	0	128,170	1.01
2.00	00200		1,958,020	1,958,020	38,196	1,996,216	2.00
2.01	00201		0	0	0	0	2.01
3.00	00300		0	0	0	0	3.00
4.00	00400	179,816	5,846,358	6,026,174	0	6,026,174	4.00
5.00	00500	2,153,138	8,992,957	11,146,095	-104,975	11,041,120	5.00
7.00	00700	367,467	1,559,028	1,926,495	0	1,926,495	7.00
8.00	00800	0	162,776	162,776	28,409	191,185	8.00
9.00	00900	393,303	205,617	598,920	-28,409	570,511	9.00
10.00	01000	778,737	375,812	1,154,549	-763,958	390,591	10.00
11.00	01100	0	0	0	763,958	763,958	11.00
13.00	01300	759,886	31,802	791,688	0	791,688	13.00
16.00	01600	1,226,009	231,551	1,457,560	0	1,457,560	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,589,450	250,611	2,840,061	-74,600	2,765,461	30.00
31.00	03100	590,890	134,632	725,522	0	725,522	31.00
43.00	04300	76,564	95,895	172,459	0	172,459	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,940,534	5,940,669	7,881,203	0	7,881,203	50.00
52.00	05200	294,130	48,730	342,860	74,600	417,460	52.00
53.00	05300	0	721,913	721,913	0	721,913	53.00
54.00	05400	782,916	1,241,163	2,024,079	0	2,024,079	54.00
54.01	05402	96,437	263,603	360,040	0	360,040	54.01
57.00	05700	130,764	446,525	577,289	0	577,289	57.00
60.00	06000	859,552	1,967,085	2,826,637	0	2,826,637	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	369,810	369,810	0	369,810	63.00
65.00	06500	413,824	87,587	501,411	0	501,411	65.00
66.00	06600	1,086,061	106,460	1,192,521	0	1,192,521	66.00
67.00	06700	105,224	44,705	149,929	0	149,929	67.00
68.00	06800	65,184	1,092	66,276	0	66,276	68.00
69.00	06900	115,745	68,850	184,595	0	184,595	69.00
70.00	07000	58,560	16,619	75,179	0	75,179	70.00
71.00	07100	39,478	378,871	418,349	15,408	433,757	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	651,485	1,459,036	2,110,521	-15,408	2,095,113	73.00
76.00	03020	150,571	193,038	343,609	0	343,609	76.00
76.01	03021	0	0	0	225,640	225,640	76.01
76.02	03022	150,131	13,107	163,238	0	163,238	76.02
76.03	03023	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
90.00	09000	727,233	102,030	829,263	12,137,959	12,967,222	90.00
91.00	09100	693,401	1,537,176	2,230,577	0	2,230,577	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	14,193	409,337	423,530	0	423,530	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	549,723	549,723	-549,723	0	113.00
114.00	11400	0	0	0	0	0	114.00
116.00	11600	325,398	254,186	579,584	0	579,584	116.00
118.00		17,816,081	37,821,131	55,637,212	11,509,963	67,147,175	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	26,430	4,630	31,060	0	31,060	194.01
194.02	07952	904,812	91,830	996,642	-996,642	0	194.02
194.03	07953	53,892	10,208	64,100	0	64,100	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	16	1,205	1,221	0	1,221	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	1,162,085	317,240	1,479,325	-1,479,325	0	194.08
194.09	07959	191,720	252,696	444,416	0	444,416	194.09
194.10	07960	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
194.12	07962	1,669,686	335,150	2,004,836	-2,004,836	0	194.12
194.13	07963	1,117,866	223,172	1,341,038	-1,341,038	0	194.13

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140143

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

Worksheet A

Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
194.14 07964 HENRY	288,178	73,140	361,318	-361,318	0	194.14
194.15 07965 LAMOILLE	0	0	0	0	0	194.15
194.16 07966 SPRING VALLEY CLINIC	646,316	86,264	732,580	-732,580	0	194.16
194.17 07967 OGLESBY MP OB	236,979	33,554	270,533	-270,533	0	194.17
194.18 07968 FAMILY HEALTH CENTER	915,845	100,929	1,016,774	-1,016,774	0	194.18
194.19 07969 GRANVILLE CLINIC	366,273	86,946	453,219	-453,219	0	194.19
194.20 07970 PARATRANSIT	0	0	0	158,277	158,277	194.20
194.21 07971 OCCUPATIONAL HEALTH	445,284	105,043	550,327	28,288	578,615	194.21
194.22 07972 SPORTS MEDICINE CLINIC	0	0	0	0	0	194.22
194.23 07973 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.23
194.24 07974 SURGICAL ASSOCIATES	0	111	111	0	111	194.24
194.25 07975 HENNEPIN CLINIC	0	0	0	0	0	194.25
194.26 07976 FAMILY HEALTH CENTER 2ND FLOOR	687,851	205,552	893,403	-893,403	0	194.26
194.27 07977 MIDTOWN	1,781,655	365,205	2,146,860	-2,146,860	0	194.27
194.28 07978 PAIN CLINIC	12,840	1,732	14,572	0	14,572	194.28
200.00 TOTAL (SUM OF LINES 118-199)	28,323,809	40,115,738	68,439,547	0	68,439,547	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140143

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

Worksheet A
Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-54,637	1,334,816	1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	0	128,170	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	6,571	2,002,787	2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP	36	36	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	-1,148,364	4,877,810	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,120,501	6,920,619	5.00
7.00	00700	OPERATION OF PLANT	-1,800	1,924,695	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	191,185	8.00
9.00	00900	HOUSEKEEPING	0	570,511	9.00
10.00	01000	DIETARY	-6,910	383,681	10.00
11.00	01100	CAFETERIA	-181,816	582,142	11.00
13.00	01300	NURSING ADMINISTRATION	-950	790,738	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-20,494	1,437,066	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,765,461	30.00
31.00	03100	INTENSIVE CARE UNIT	0	725,522	31.00
43.00	04300	NURSERY	-78,000	94,459	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-49,703	7,831,500	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	417,460	52.00
53.00	05300	ANESTHESIOLOGY	-492,424	229,489	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,024,079	54.00
54.01	05402	NUCLEAR MEDICINE	0	360,040	54.01
57.00	05700	CT SCAN	0	577,289	57.00
60.00	06000	LABORATORY	0	2,826,637	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	369,810	63.00
65.00	06500	RESPIRATORY THERAPY	0	501,411	65.00
66.00	06600	PHYSICAL THERAPY	-67,760	1,124,761	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	149,929	67.00
68.00	06800	SPEECH PATHOLOGY	0	66,276	68.00
69.00	06900	ELECTROCARDIOLOGY	-24,222	160,373	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-2,340	72,839	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	433,757	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-334,595	1,760,518	73.00
76.00	03020	SONOGRAPHY	-57,100	286,509	76.00
76.01	03021	AUDIOLOGY	0	225,640	76.01
76.02	03022	CARDIAC REHAB	0	163,238	76.02
76.03	03023	ECP	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	-6,594,465	6,372,757	90.00
91.00	09100	EMERGENCY	-948,318	1,282,259	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	423,530	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
116.00	11600	HOSPICE	0	579,584	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-14,177,792	52,969,383	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	194.00
194.01	07951	CONGREGATE LIVING	0	31,060	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICINE	0	0	194.02
194.03	07953	MANAGED CARE	0	64,100	194.03
194.04	07954	RENTAL AREA/PPOS	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	1,221	194.05
194.06	07956	LASALLE SELLETT SUITE	0	0	194.06
194.07	07957	LASALLE STANMAR SUITE	0	0	194.07
194.08	07958	ENT	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	444,416	194.09
194.10	07960	PERU MALL	0	0	194.10
194.11	07961	LADD	0	0	194.11
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	194.13
194.14	07964	HENRY	0	0	194.14
194.15	07965	LAMOILLE	0	0	194.15

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140143

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

Worksheet A
Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
194.16	07966 SPRING VALLEY CLINIC	0	0	194.16
194.17	07967 OGLESBY MP OB	0	0	194.17
194.18	07968 FAMILY HEALTH CENTER	0	0	194.18
194.19	07969 GRANVILLE CLINIC	0	0	194.19
194.20	07970 PARATRANSIT	0	158,277	194.20
194.21	07971 OCCUPATIONAL HEALTH	0	578,615	194.21
194.22	07972 SPORTS MEDICINE CLINIC	0	0	194.22
194.23	07973 OTHER NONREIMBURSABLE COST CENTERS	0	0	194.23
194.24	07974 SURGICAL ASSOCIATES	0	111	194.24
194.25	07975 HENNEPIN CLINIC	0	0	194.25
194.26	07976 FAMILY HEALTH CENTER 2ND FLOOR	0	0	194.26
194.27	07977 MIDTOWN	0	0	194.27
194.28	07978 PAIN CLINIC	0	14,572	194.28
200.00	TOTAL (SUM OF LINES 118-199)	-14,177,792	54,261,755	200.00

RECLASSIFICATIONS

Provider CCN: 140143

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

Worksheet A-6

Date/Time Prepared:
2/27/2013 9:29 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - IV COSTS FROM PHARMACY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	15,408	1.00
	TOTALS		0	15,408	
B - DIETARY RECLASS					
1.00	CAFETERIA	11.00	515,290	248,668	1.00
	TOTALS		515,290	248,668	
C - LAUNDRY SALARIES					
1.00	LAUNDRY & LINEN SERVICE	8.00	28,409	0	1.00
	TOTALS		28,409	0	
D - DEPRECIATION FOR OFF CAMPUS CLINICS					
1.00	CLINIC	90.00	0	666,946	1.00
2.00	OCCUPATIONAL HEALTH	194.21	0	28,288	2.00
3.00	CLINIC	90.00	0	125	3.00
	TOTALS		0	695,359	
E - AUDIOLOGY COSTS					
1.00	AUDIOLOGY	76.01	0	225,640	1.00
	TOTALS		0	225,640	
F - INTEREST EXPENSE ON EQUIPMENT					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	38,196	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	53,302	2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	458,225	3.00
	TOTALS		0	549,723	
G - PARATRANSIT COSTS					
1.00	PARATRANSIT	194.20	110,262	48,015	1.00
	TOTALS		110,262	48,015	
H - LABOR AND DELIVERY SALARIES					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	74,600	0	1.00
	TOTALS		74,600	0	
I - PROV BASED CLINIC SALARIES					
1.00	CLINIC	90.00	9,777,546	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
	TOTALS		9,777,546	0	
J - PROVIDER BASED OTHER EXPENSES					
1.00	CLINIC	90.00	0	1,693,342	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
	TOTALS		0	1,693,342	
500.00	Grand Total: Increases		10,506,107	3,476,155	500.00

RECLASSIFICATIONS

Provider CCN: 140143

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

Worksheet A-6
Date/Time Prepared:
2/27/2013 9:29 am

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
A - IV COSTS FROM PHARMACY							
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	15,408	0		1.00
	TOTALS		0	15,408			
B - DIETARY RECLASS							
1.00	DIETARY	10.00	515,290	248,668	0		1.00
	TOTALS		515,290	248,668			
C - LAUNDRY SALARIES							
1.00	HOUSEKEEPING	9.00	28,409	0	0		1.00
	TOTALS		28,409	0			
D - DEPRECIATION FOR OFF CAMPUS CLINICS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	695,359	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
	TOTALS		0	695,359			
E - AUDIOLOGY COSTS							
1.00	ENT	194.08	0	225,640	0		1.00
	TOTALS		0	225,640			
F - INTEREST EXPENSE ON EQUIPMENT							
1.00	INTEREST EXPENSE	113.00	0	549,723	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	549,723			
G - PARATRANSIT COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	110,262	48,015	0		1.00
	TOTALS		110,262	48,015			
H - LABOR AND DELIVERY SALARIES							
1.00	ADULTS & PEDIATRICS	30.00	74,600	0	0		1.00
	TOTALS		74,600	0			
I - PROV BASED CLINIC SALARIES							
1.00	ENT	194.08	1,162,085	0	0		1.00
2.00	FAMILY ORTHOPEDIC CENTER	194.12	1,669,686	0	0		2.00
3.00	WOMEN'S HEALTH CENTER	194.13	1,117,866	0	0		3.00
4.00	HENRY	194.14	288,178	0	0		4.00
5.00	SPRING VALLEY CLINIC	194.16	646,316	0	0		5.00
6.00	OGLESBY MP OB	194.17	236,979	0	0		6.00
7.00	FAMILY HEALTH CENTER	194.18	915,845	0	0		7.00
8.00	GRANVILLE CLINIC	194.19	366,273	0	0		8.00
9.00	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	194.02	904,812	0	0		9.00
10.00	FAMILY HEALTH CENTER 2ND FLOOR	194.26	687,851	0	0		10.00
11.00	MIDTOWN	194.27	1,781,655	0	0		11.00
	TOTALS		9,777,546	0			
J - PROVIDER BASED OTHER EXPENSES							
1.00	ENT	194.08	0	91,600	0		1.00
2.00	FAMILY ORTHOPEDIC CENTER	194.12	0	335,150	0		2.00
3.00	WOMEN'S HEALTH CENTER	194.13	0	223,172	0		3.00
4.00	HENRY	194.14	0	73,140	0		4.00
5.00	SPRING VALLEY CLINIC	194.16	0	86,264	0		5.00
6.00	OGLESBY MP OB	194.17	0	33,554	0		6.00
7.00	FAMILY HEALTH CENTER	194.18	0	100,929	0		7.00
8.00	GRANVILLE CLINIC	194.19	0	86,946	0		8.00
9.00	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	194.02	0	91,830	0		9.00
10.00	FAMILY HEALTH CENTER 2ND FLOOR	194.26	0	205,552	0		10.00
11.00	MIDTOWN	194.27	0	365,205	0		11.00
	TOTALS		0	1,693,342			
500.00	Grand Total: Decreases		10,506,107	3,476,155			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140143

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/27/2013 9:29 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,654,274	0	0	0	189,972	1.00
2.00	Land Improvements	2,372,543	121,242	0	121,242	174,521	2.00
3.00	Buildings and Fixtures	45,732,883	5,921,847	0	5,921,847	698,903	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	24,534,337	2,831,688	0	2,831,688	5,398,894	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	75,294,037	8,874,777	0	8,874,777	6,462,290	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	75,294,037	8,874,777	0	8,874,777	6,462,290	10.00
SUMMARY OF CAPITAL							
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,626,587	0	0	0	0	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	128,170	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,958,020	0	0	0	0	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	3,712,777	0	0	0	0	3.00
COMPUTATION OF RATIOS							
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	54,656,098	0	54,656,098	0.703366	0	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	1,083,295	0	1,083,295	0.013941	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	21,956,452	0	21,956,452	0.282556	0	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	10,679	0	10,679	0.000137	0	2.01
3.00	Total (sum of lines 1-2)	77,706,524	0	77,706,524	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140143

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/27/2013 9:29 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,464,302	0		1.00		
2.00	Land Improvements	2,319,264	0		2.00		
3.00	Buildings and Fixtures	50,955,827	0		3.00		
4.00	Building Improvements	0	0		4.00		
5.00	Fixed Equipment	0	0		5.00		
6.00	Movable Equipment	21,967,131	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	77,706,524	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	77,706,524	0		10.00		
SUMMARY OF CAPITAL							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,626,587		1.00		
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	128,170		1.01		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,958,020		2.00		
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0		2.01		
3.00	Total (sum of lines 1-2)	0	3,712,777		3.00		
ALLOCATION OF OTHER CAPITAL							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	931,228	0	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	0	0	128,170	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,964,591	0	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	36	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	3,024,025	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140143

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	403,588	0	0	0	1,334,816	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	0	0	0	128,170	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	38,196	0	0	0	2,002,787	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	0	36	2.01
3.00	Total (sum of lines 1-2)	441,784	0	0	0	3,465,809	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140143

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

Worksheet A-8

Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
			Cost Center	Line #
			1.00	2.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-53,992	NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
1.01 Investment income - OLD CAP REL COSTS-BLDG & FIXT (chapter 2)			OLD CAP REL COSTS-BLDG & FIXT	1.01 1.01
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP	2.00 2.00
2.01 Investment income - OLD CAP REL COSTS-MVBLE EQUIP (chapter 2)			OLD CAP REL COSTS-MVBLE EQUIP	2.01 2.01
3.00 Investment income - other (chapter 2)		0		0.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-5,016	ADMINISTRATIVE & GENERAL	5.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00 7.00
8.00 Television and radio service (chapter 21)	A	-1,800	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	-8,397,598		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	-29,854		12.00
13.00 Laundry and linen service		0		0.00 13.00
14.00 Cafeteria-employees and guests	B	-181,816	CAFETERIA	11.00 14.00
15.00 Rental of quarters to employee and others		0		0.00 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00 Sale of drugs to other than patients	B	-334,595	DRUGS CHARGED TO PATIENTS	73.00 17.00
18.00 Sale of medical records and abstracts	B	-20,494	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00 Vending machines	B	-6,910	DIETARY	10.00 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)			UTILIZATION REVIEW-SNF	114.00 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
26.01 Depreciation - OLD CAP REL COSTS-BLDG & FIXT			OLD CAP REL COSTS-BLDG & FIXT	1.01 26.01
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2.00 27.00
27.01 Depreciation - OLD CAP REL COSTS-MVBLE EQUIP			OLD CAP REL COSTS-MVBLE EQUIP	2.01 27.01
28.00 Non-physician Anesthetist			*** Cost Center Deleted ***	19.00 28.00
29.00 Physicians' assistant		0		0.00 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00 32.00
33.00		0		0.00 33.00
33.01 OUTSIDE PHYSICAL THERAPY	B	-67,760	PHYSICAL THERAPY	66.00 33.01
33.03 OB COMMISSIONS	B	-250	ADMINISTRATIVE & GENERAL	5.00 33.03
33.04 HOME OFFICE OPERATING INTEREST INCOM	B	-645	NEW CAP REL COSTS-BLDG & FIXT	1.00 33.04
33.06 PATIENT PHONES	A	-26,376	ADMINISTRATIVE & GENERAL	5.00 33.06
33.07 PATIENT PHONES DEPRECIATION	A	-7,048	NEW CAP REL COSTS-MVBLE EQUIP	2.00 33.07
33.10 MISC INCOME	B	-27,788	ADMINISTRATIVE & GENERAL	5.00 33.10
33.11 PHYSICIAN RECRUITMENT	A	-20,163	ADMINISTRATIVE & GENERAL	5.00 33.11
33.12 EMPLOYEE HEALTH	A	-947,635	EMPLOYEE BENEFITS	4.00 33.12
33.13 PROVISION FOR BAD DEBTS	A	-3,976,169	ADMINISTRATIVE & GENERAL	5.00 33.13

Provider CCN: 140143 Period: From 10/01/2011 To 09/30/2012 Worksheet A-8
 Date/Time Prepared: 2/27/2013 9:29 am

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	
33.15 ADMIN COSTS FOR POB	A	217	ADMINISTRATIVE & GENERAL	5.00	33.15
33.16		0		0.00	33.16
33.17 LOBBYING PORTION OF IHHA DUES	A	-21,447	ADMINISTRATIVE & GENERAL	5.00	33.17
33.18 PATIENT EDUCATION REVENUE	B	-950	NURSING ADMINISTRATION	13.00	33.18
34.00 MISC REVENUE	B	-49,703	OPERATING ROOM	50.00	34.00
35.00		0		0.00	35.00
36.00		0		0.00	36.00
37.00		0		0.00	37.00
38.00		0		0.00	38.00
39.00		0		0.00	39.00
40.00		0		0.00	40.00
41.00		0		0.00	41.00
42.00		0		0.00	42.00
43.00		0		0.00	43.00
44.00		0		0.00	44.00
45.00		0		0.00	45.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-14,177,792			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140143

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

Worksheet A-8

Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	11	1.00
1.01	Investment income - OLD CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
2.01	Investment income - OLD CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.01
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
26.01	Depreciation - OLD CAP REL COSTS-BLDG & FIXT	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
27.01	Depreciation - OLD CAP REL COSTS-MVBLE EQUIP	0	27.01
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		0	33.00
33.01	OUTSIDE PHYSICAL THERAPY	0	33.01
33.03	OB COMMISSIONS	0	33.03
33.04	HOME OFFICE OPERATING INTEREST INCOM	11	33.04
33.06	PATIENT PHONES	0	33.06
33.07	PATIENT PHONES DEPRECIATION	9	33.07
33.10	MISC INCOME	0	33.10
33.11	PHYSICIAN RECRUITMENT	0	33.11
33.12	EMPLOYEE HEALTH	0	33.12
33.13	PROVISION FOR BAD DEBTS	0	33.13
33.15	ADMIN COSTS FOR POB	0	33.15
33.16		0	33.16
33.17	LOBBYING PORTION OF IHHA DUES	0	33.17
33.18	PATIENT EDUCATION REVENUE	0	33.18
34.00	MISC REVENUE	0	34.00
35.00		0	35.00
36.00		0	36.00
37.00		0	37.00
38.00		0	38.00
39.00		0	39.00
40.00		0	40.00
41.00		0	41.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140143

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

Worksheet A-8

Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
42.00		0	42.00
43.00		0	43.00
44.00		0	44.00
45.00		0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 140143

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

Worksheet A-8-1

Date/Time Prepared:
2/27/2013 9:29 am

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	SISTERS SALARIES	2.00
3.00		2.01	OLD CAP REL COSTS-MVBLE EQUIP	OLD CAPITAL COSTS	3.00
4.00		2.00	NEW CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL COSTS	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00

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

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

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

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

6.00		B		0.00	6.00
7.00		G	SMP HEALTH CORP	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:		NON-FINANCIAL		100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 140143

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

Worksheet A-8-1

Date/Time Prepared: 2/27/2013 9:29 am

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1,283,955	1,321,464	-37,509	0	1.00
2.00	0	6,000	-6,000	0	2.00
3.00	36	0	36	9	3.00
4.00	13,619	0	13,619	9	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00
	1,297,610	1,327,464	-29,854		

* 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		SRS OF MARY OF THE PRES	100.00	RELIGIOUS COMMUNITY	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: 140143

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

Worksheet A-8-2

Date/Time Prepared:
2/27/2013 9:29 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	53.00	ANESTHESIOLOGY	521,414	431,144	1.00
2.00	91.00	EMERGENCY	1,252,432	619,453	2.00
3.00	43.00	NURSERY	78,000	78,000	3.00
4.00	60.00	LABORATORY	35,000	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	24,222	24,222	5.00
6.00	76.00	SONOGRAPHY	57,100	57,100	6.00
7.00	70.00	ELECTROENCEPHALOGRAPHY	2,340	2,340	7.00
8.00	90.00	CLINIC	6,590,229	6,590,229	8.00
9.00	4.00	EMPLOYEE BENEFITS	200,729	200,729	9.00
10.00	90.00	CLINIC	4,236	4,236	10.00
200.00			8,765,702	8,007,453	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140143

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

Worksheet A-8-2

Date/Time Prepared:
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	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	90,270	167,500	360	28,990	1,450	1.00
2.00	632,979	142,500	4,439	304,114	15,206	2.00
3.00	0	0	0	0	0	3.00
4.00	35,000	208,000	520	52,000	2,600	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	758,249		5,319	385,104	19,256	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140143

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

Worksheet A-8-2

Date/Time Prepared:
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	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	28,990	1.00
2.00	0	0	0	0	304,114	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	52,000	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	385,104	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140143

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

Worksheet A-8-2

Date/Time Prepared:
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	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	61,280	492,424	1.00
2.00	328,865	948,318	2.00
3.00	0	78,000	3.00
4.00	0	0	4.00
5.00	0	24,222	5.00
6.00	0	57,100	6.00
7.00	0	2,340	7.00
8.00	0	6,590,229	8.00
9.00	0	200,729	9.00
10.00	0	4,236	10.00
200.00	390,145	8,397,598	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140143

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

Worksheet B
Part I
Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
		0	1.00	1.01	2.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	1,334,816	1,334,816				1.00
1.01 00101 OLD CAP REL COSTS-BLDG & FIXT	128,170	0	128,170			1.01
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	2,002,787			2,002,787		2.00
2.01 00201 OLD CAP REL COSTS-MVBLE EQUIP	36			0	36	2.01
4.00 00400 EMPLOYEE BENEFITS	4,877,810	4,972	477	0	0	4.00
5.00 00500 ADMINISTRATIVE & GENERAL	6,920,619	456,963	43,880	615,776	36	5.00
7.00 00700 OPERATION OF PLANT	1,924,695	137,934	13,245	82,391	0	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	191,185	3,570	343	0	0	8.00
9.00 00900 HOUSEKEEPING	570,511	14,247	1,368	313	0	9.00
10.00 01000 DIETARY	383,681	36,663	3,520	23,151	0	10.00
11.00 01100 CAFETERIA	582,142	12,183	1,170	0	0	11.00
13.00 01300 NURSING ADMINISTRATION	790,738	14,157	1,359	894	0	13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1,437,066	18,860	1,811	27,500	0	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	2,765,461	117,393	11,272	113,383	0	30.00
31.00 03100 INTENSIVE CARE UNIT	725,522	22,906	2,199	9,991	0	31.00
43.00 04300 NURSERY	94,459	5,489	527	5,522	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	7,831,500	72,642	6,975	509,056	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	417,460	2,765	265	20,545	0	52.00
53.00 05300 ANESTHESIOLOGY	229,489	2,783	267	30,777	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,024,079	33,116	3,180	117,119	0	54.00
54.01 05402 NUCLEAR MEDICINE	360,040	5,647	542	23	0	54.01
57.00 05700 CT SCAN	577,289	2,922	281	781	0	57.00
60.00 06000 LABORATORY	2,826,637	17,574	1,687	59,151	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	369,810	1,052	101	964	0	63.00
65.00 06500 RESPIRATORY THERAPY	501,411	5,260	505	29,318	0	65.00
66.00 06600 PHYSICAL THERAPY	1,124,761	46,675	4,482	10,323	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	149,929	175	17	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	66,276	791	76	851	0	68.00
69.00 06900 ELECTROCARDIOLOGY	160,373	593	57	10,719	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	72,839	9,495	912	14,977	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	433,757	33,925	3,257	29,799	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,760,518	9,531	915	9,439	0	73.00
76.00 03020 SONOGRAPHY	286,509	2,405	231	27,340	0	76.00
76.01 03021 AUDIOLOGY	225,640	0	0	0	0	76.01
76.02 03022 CARDIAC REHAB	163,238	6,703	644	13,180	0	76.02
76.03 03023 ECP	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 09000 CLINIC	6,372,757	76,248	7,321	205,199	0	90.00
91.00 09100 EMERGENCY	1,282,259	24,740	2,376	6,116	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	423,530	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
116.00 11600 HOSPICE	579,584	4,379	420	1,445	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	52,969,383	1,204,758	115,682	1,976,043	36	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,002	576	0	0	190.00
194.00 07950 ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01 07951 CONGREGATE LIVING	31,060	59,677	5,730	0	0	194.01
194.02 07952 VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03 07953 MANAGED CARE	64,100	0	0	0	0	194.03
194.04 07954 RENTAL AREA/PPOS	0	51,341	4,930	0	0	194.04
194.05 07955 SPECIALTY CLINICS	1,221	0	0	0	0	194.05
194.06 07956 LASALLE SELLETT SUITE	0	0	0	0	0	194.06
194.07 07957 LASALLE STANMAR SUITE	0	0	0	0	0	194.07
194.08 07958 ENT	0	0	0	0	0	194.08
194.09 07959 DURABLE MEDICAL EQUIPMENT	444,416	13,038	1,252	1,040	0	194.09
194.10 07960 PERU MALL	0	0	0	0	0	194.10
194.11 07961 LADD	0	0	0	0	0	194.11

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140143

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

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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
	0	1.00	1.01	2.00	2.01	
194.12 07962 FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	0 194.12
194.13 07963 WOMEN'S HEALTH CENTER	0	0	0	0	0	0 194.13
194.14 07964 HENRY	0	0	0	0	0	0 194.14
194.15 07965 LAMOILLE	0	0	0	0	0	0 194.15
194.16 07966 SPRING VALLEY CLINIC	0	0	0	0	0	0 194.16
194.17 07967 OGLESBY MP OB	0	0	0	0	0	0 194.17
194.18 07968 FAMILY HEALTH CENTER	0	0	0	0	0	0 194.18
194.19 07969 GRANVILLE CLINIC	0	0	0	0	0	0 194.19
194.20 07970 PARATRANSIT	158,277	0	0	22,627	0	0 194.20
194.21 07971 OCCUPATIONAL HEALTH	578,615	0	0	3,077	0	0 194.21
194.22 07972 SPORTS MEDICINE CLINIC	0	0	0	0	0	0 194.22
194.23 07973 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	0 194.23
194.24 07974 SURGICAL ASSOCIATES	111	0	0	0	0	0 194.24
194.25 07975 HENNEPIN CLINIC	0	0	0	0	0	0 194.25
194.26 07976 FAMILY HEALTH CENTER 2ND FLOOR	0	0	0	0	0	0 194.26
194.27 07977 MIDTOWN	0	0	0	0	0	0 194.27
194.28 07978 PAIN CLINIC	14,572	0	0	0	0	0 194.28
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						0 201.00
202.00 TOTAL (sum lines 118-201)	54,261,755	1,334,816	128,170	2,002,787	36	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140143

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

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Cost Center Description			EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS	4,883,259					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	462,838	8,500,112	8,500,112			5.00
7.00	00700	OPERATION OF PLANT	83,254	2,241,519	416,358	2,657,877		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,436	201,534	37,435	12,909	251,878	8.00
9.00	00900	HOUSEKEEPING	82,671	669,110	124,286	51,523	0	9.00
10.00	01000	DIETARY	59,687	506,702	94,119	132,588	0	10.00
11.00	01100	CAFETERIA	116,745	712,240	132,297	44,061	0	11.00
13.00	01300	NURSING ADMINISTRATION	172,161	979,309	181,905	51,198	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	277,767	1,763,004	327,474	68,204	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	569,769	3,577,278	664,472	424,544	163,804	30.00
31.00	03100	INTENSIVE CARE UNIT	133,873	894,491	166,150	82,837	13,425	31.00
43.00	04300	NURSERY	17,346	123,343	22,911	19,852	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	439,651	8,859,824	1,645,673	262,705	26,699	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	83,540	524,575	97,439	9,999	0	52.00
53.00	05300	ANESTHESIOLOGY	0	263,316	48,910	10,064	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	177,379	2,354,873	437,413	119,760	16,800	54.00
54.01	05402	NUCLEAR MEDICINE	21,849	388,101	72,089	20,421	0	54.01
57.00	05700	CT SCAN	29,626	610,899	113,473	10,568	3,350	57.00
60.00	06000	LABORATORY	194,742	3,099,791	575,780	63,555	126	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	371,927	69,085	3,804	0	63.00
65.00	06500	RESPIRATORY THERAPY	93,757	630,251	117,068	19,022	492	65.00
66.00	06600	PHYSICAL THERAPY	246,060	1,432,301	266,047	168,796	13,425	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,840	173,961	32,313	634	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,768	82,762	15,373	2,861	0	68.00
69.00	06900	ELECTROCARDIOLOGY	26,223	197,965	36,772	2,146	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,267	111,490	20,709	34,338	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,944	509,682	94,672	122,687	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	147,602	1,928,005	358,123	34,468	0	73.00
76.00	03020	SONOGRAPHY	34,114	350,599	65,123	8,698	0	76.00
76.01	03021	AUDIOLOGY	0	225,640	41,912	0	0	76.01
76.02	03022	CARDIAC REHAB	34,014	217,779	40,452	24,241	0	76.02
76.03	03023	ECP	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	886,887	7,548,412	1,402,102	275,744	0	90.00
91.00	09100	EMERGENCY	157,098	1,472,589	273,530	89,471	13,425	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	3,216	426,746	79,267	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	73,723	659,551	122,510	15,836	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,692,847	52,609,681	8,193,242	2,187,534	251,546	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,578	1,222	21,705	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	5,988	102,455	19,031	215,816	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	12,210	76,310	14,174	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	56,271	10,452	185,672	0	194.04
194.05	07955	SPECIALTY CLINICS	4	1,225	228	0	332	194.05
194.06	07956	LASALLE SELLETT SUITE	0	0	0	0	0	194.06
194.07	07957	LASALLE STANMAR SUITE	0	0	0	0	0	194.07
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	43,436	503,182	93,465	47,150	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.11	07961	LADD	0	0	0	0	0	194.11
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.15	07965	LAMOILLE	0	0	0	0	0	194.15
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140143

Period:
From 10/01/2011
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Cost Center Description		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		4.00	4A	5.00	7.00	8.00	
194.17	07967 OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968 FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969 GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970 PARATRANSIT	24,981	205,885	38,243	0	0	194.20
194.21	07971 OCCUPATIONAL HEALTH	100,884	682,576	126,787	0	0	194.21
194.22	07972 SPORTS MEDICINE CLINIC	0	0	0	0	0	194.22
194.23	07973 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.23
194.24	07974 SURGICAL ASSOCIATES	0	111	21	0	0	194.24
194.25	07975 HENNEPIN CLINIC	0	0	0	0	0	194.25
194.26	07976 FAMILY HEALTH CENTER 2ND FLOOR	0	0	0	0	0	194.26
194.27	07977 MIDDTOWN	0	0	0	0	0	194.27
194.28	07978 PAIN CLINIC	2,909	17,481	3,247	0	0	194.28
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	4,883,259	54,261,755	8,500,112	2,657,877	251,878	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet B Part I Date/Time Prepared: 2/27/2013 9:29 am			
Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
		9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP					2.01
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	844,919				9.00
10.00	01000	DIETARY	41,732	775,141			10.00
11.00	01100	CAFETERIA	33,376	0	921,974		11.00
13.00	01300	NURSING ADMINISTRATION	25,088	0	36,409	1,273,909	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	50,753	0	115,318	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	324,011	529,959	213,041	603,928	130,682
31.00	03100	INTENSIVE CARE UNIT	41,554	69,541	38,344	108,711	21,397
43.00	04300	NURSERY	3,800	0	8,708	24,644	6,717
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	67,175	54,658	130,011	368,580	426,707
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,821	0	17,954	50,925	9,730
53.00	05300	ANESTHESIOLOGY	667	0	0	0	75,658
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,954	0	54,757	0	151,695
54.01	05402	NUCLEAR MEDICINE	1,511	0	5,232	0	29,069
57.00	05700	CT SCAN	1,511	0	7,418	0	167,153
60.00	06000	LABORATORY	16,821	0	67,693	0	308,070
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,755	0	0	0	9,789
65.00	06500	RESPIRATORY THERAPY	4,044	0	25,300	0	47,707
66.00	06600	PHYSICAL THERAPY	8,355	0	0	0	99,057
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	11,742
68.00	06800	SPEECH PATHOLOGY	1,511	0	0	0	3,443
69.00	06900	ELECTROCARDIOLOGY	2,622	0	7,060	0	43,142
70.00	07000	ELECTROENCEPHALOGRAPHY	578	0	4,945	0	10,411
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,044	0	5,339	0	125,818
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	16,821	0	30,030	0	86,224
76.00	03020	SONOGRAPHY	1,511	0	7,705	0	58,253
76.01	03021	AUDIOLOGY	1,511	0	0	0	6,029
76.02	03022	CARDIAC REHAB	0	0	0	0	10,514
76.03	03023	ECP	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
90.00	09000	CLINIC	0	0	55,007	0	71,207
91.00	09100	EMERGENCY	16,821	0	41,318	117,121	86,094
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	6,184
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
114.00	11400	UTILIZATION REVIEW-SNF					
116.00	11600	HOSPICE	0	0	23,042	0	29,765
118.00		SUBTOTALS (SUM OF LINES 1-117)	709,347	654,158	894,631	1,273,909	2,032,257
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,511	0	0	0	0
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	66,019
194.01	07951	CONGREGATE LIVING	0	120,983	2,831	0	0
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	28,238
194.03	07953	MANAGED CARE	0	0	3,584	0	0
194.04	07954	RENTAL AREA/PPOS	134,061	0	0	0	0
194.05	07955	SPECIALTY CLINICS	0	0	0	0	4,290
194.06	07956	LASALLE SELLETT SUITE	0	0	0	0	0
194.07	07957	LASALLE STANMAR SUITE	0	0	0	0	0
194.08	07958	ENT	0	0	0	0	22,229
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	0	7,571
194.10	07960	PERU MALL	0	0	0	0	0
194.11	07961	LADD	0	0	0	0	0
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	42,519
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	34,385
194.14	07964	HENRY	0	0	0	0	2,155
194.15	07965	LAMOILLE	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
	9.00	10.00	11.00	13.00	16.00	
194.16 07966 SPRING VALLEY CLINIC	0	0	0	0	7,297	194.16
194.17 07967 OGLESBY MP OB	0	0	0	0	4,067	194.17
194.18 07968 FAMILY HEALTH CENTER	0	0	0	0	16,201	194.18
194.19 07969 GRANVILLE CLINIC	0	0	0	0	5,293	194.19
194.20 07970 PARATRANSIT	0	0	0	0	0	194.20
194.21 07971 OCCUPATIONAL HEALTH	0	0	20,928	0	4,709	194.21
194.22 07972 SPORTS MEDICINE CLINIC	0	0	0	0	0	194.22
194.23 07973 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.23
194.24 07974 SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.25 07975 HENNEPIN CLINIC	0	0	0	0	0	194.25
194.26 07976 FAMILY HEALTH CENTER 2ND FLOOR	0	0	0	0	14,732	194.26
194.27 07977 MIDTOWN	0	0	0	0	32,751	194.27
194.28 07978 PAIN CLINIC	0	0	0	0	40	194.28
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						0 201.00
202.00 TOTAL (sum lines 118-201)	844,919	775,141	921,974	1,273,909	2,324,753	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140143

Period:
From 10/01/2011
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP				2.01
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
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,631,719	0	6,631,719
31.00	03100	INTENSIVE CARE UNIT	0	1,436,450	0	1,436,450
43.00	04300	NURSERY	0	209,975	0	209,975
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	11,842,032	0	11,842,032
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	727,443	0	727,443
53.00	05300	ANESTHESIOLOGY	0	398,615	0	398,615
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,160,252	0	3,160,252
54.01	05402	NUCLEAR MEDICINE	0	516,423	0	516,423
57.00	05700	CT SCAN	0	914,372	0	914,372
60.00	06000	LABORATORY	0	4,131,836	0	4,131,836
60.01	06001	BLOOD LABORATORY	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	456,360	0	456,360
65.00	06500	RESPIRATORY THERAPY	0	843,884	0	843,884
66.00	06600	PHYSICAL THERAPY	0	1,987,981	0	1,987,981
67.00	06700	OCCUPATIONAL THERAPY	0	218,650	0	218,650
68.00	06800	SPEECH PATHOLOGY	0	105,950	0	105,950
69.00	06900	ELECTROCARDIOLOGY	0	289,707	0	289,707
70.00	07000	ELECTROENCEPHALOGRAPHY	0	182,471	0	182,471
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	862,242	0	862,242
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,453,671	0	2,453,671
76.00	03020	SONOGRAPHY	0	491,889	0	491,889
76.01	03021	AUDIOLOGY	0	275,092	0	275,092
76.02	03022	CARDIAC REHAB	0	292,986	0	292,986
76.03	03023	ECP	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0
90.00	09000	CLINIC	0	9,352,472	0	9,352,472
91.00	09100	EMERGENCY	0	2,110,369	0	2,110,369
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	512,197	0	512,197
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
116.00	11600	HOSPICE	0	850,704	0	850,704
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	51,255,742	0	51,255,742
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	31,016	0	31,016
194.00	07950	ER PROFESSIONAL CHARGES	0	66,019	0	66,019
194.01	07951	CONGREGATE LIVING	0	461,116	0	461,116
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	28,238	0	28,238
194.03	07953	MANAGED CARE	0	94,068	0	94,068
194.04	07954	RENTAL AREA/PPOS	0	386,456	0	386,456
194.05	07955	SPECIALTY CLINICS	0	6,075	0	6,075
194.06	07956	LASALLE SELLETT SUITE	0	0	0	0
194.07	07957	LASALLE STANMAR SUITE	0	0	0	0
194.08	07958	ENT	0	22,229	0	22,229
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	651,368	0	651,368
194.10	07960	PERU MALL	0	0	0	0
194.11	07961	LADD	0	0	0	0
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	42,519	0	42,519
194.13	07963	WOMEN'S HEALTH CENTER	0	34,385	0	34,385

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140143

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
194.14	07964	HENRY	0	2,155	0	2,155	194.14
194.15	07965	LAMOLLE	0	0	0	0	194.15
194.16	07966	SPRING VALLEY CLINIC	0	7,297	0	7,297	194.16
194.17	07967	OGLESBY MP OB	0	4,067	0	4,067	194.17
194.18	07968	FAMILY HEALTH CENTER	0	16,201	0	16,201	194.18
194.19	07969	GRANVILLE CLINIC	0	5,293	0	5,293	194.19
194.20	07970	PARATRANSIT	0	244,128	0	244,128	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	835,000	0	835,000	194.21
194.22	07972	SPORTS MEDICINE CLINIC	0	0	0	0	194.22
194.23	07973	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.23
194.24	07974	SURGICAL ASSOCIATES	0	132	0	132	194.24
194.25	07975	HENNEPIN CLINIC	0	0	0	0	194.25
194.26	07976	FAMILY HEALTH CENTER 2ND FLOOR	0	14,732	0	14,732	194.26
194.27	07977	MIDTOWN	0	32,751	0	32,751	194.27
194.28	07978	PAIN CLINIC	0	20,768	0	20,768	194.28
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	54,261,755	0	54,261,755	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140143

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

Worksheet B
Part II
Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
			1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
2.01	00201						2.01
4.00	00400	0	4,972	477	0	0	4.00
5.00	00500	173,822	456,963	43,880	615,776	36	5.00
7.00	00700	843	137,934	13,245	82,391	0	7.00
8.00	00800	0	3,570	343	0	0	8.00
9.00	00900	2,631	14,247	1,368	313	0	9.00
10.00	01000	0	36,663	3,520	23,151	0	10.00
11.00	01100	0	12,183	1,170	0	0	11.00
13.00	01300	0	14,157	1,359	894	0	13.00
16.00	01600	0	18,860	1,811	27,500	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	15,641	117,393	11,272	113,383	0	30.00
31.00	03100	71,852	22,906	2,199	9,991	0	31.00
43.00	04300	0	5,489	527	5,522	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	253,765	72,642	6,975	509,056	0	50.00
52.00	05200	0	2,765	265	20,545	0	52.00
53.00	05300	65,459	2,783	267	30,777	0	53.00
54.00	05400	351,429	33,116	3,180	117,119	0	54.00
54.01	05402	0	5,647	542	23	0	54.01
57.00	05700	304,683	2,922	281	781	0	57.00
60.00	06000	0	17,574	1,687	59,151	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	1,052	101	964	0	63.00
65.00	06500	9,742	5,260	505	29,318	0	65.00
66.00	06600	15,165	46,675	4,482	10,323	0	66.00
67.00	06700	0	175	17	0	0	67.00
68.00	06800	0	791	76	851	0	68.00
69.00	06900	23,028	593	57	10,719	0	69.00
70.00	07000	0	9,495	912	14,977	0	70.00
71.00	07100	128,563	33,925	3,257	29,799	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	21,444	9,531	915	9,439	0	73.00
76.00	03020	0	2,405	231	27,340	0	76.00
76.01	03021	0	0	0	0	0	76.01
76.02	03022	0	6,703	644	13,180	0	76.02
76.03	03023	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
90.00	09000	0	76,248	7,321	205,199	0	90.00
91.00	09100	36,209	24,740	2,376	6,116	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
114.00	11400	0	0	0	0	0	114.00
116.00	11600	30,434	4,379	420	1,445	0	116.00
118.00		1,504,710	1,204,758	115,682	1,976,043	36	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	6,002	576	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	59,677	5,730	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	51,341	4,930	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	13,038	1,252	1,040	0	194.09
194.10	07960	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
194.12	07962	0	0	0	0	0	194.12

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140143

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

Worksheet B
Part II
Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
		1.00	1.01	2.00	2.01	
194.13 07963 WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14 07964 HENRY	0	0	0	0	0	194.14
194.15 07965 LAMOILLE	0	0	0	0	0	194.15
194.16 07966 SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17 07967 OGLESBY MP OB	0	0	0	0	0	194.17
194.18 07968 FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19 07969 GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20 07970 PARATRANSIT	0	0	0	22,627	0	194.20
194.21 07971 OCCUPATIONAL HEALTH	0	0	0	3,077	0	194.21
194.22 07972 SPORTS MEDICINE CLINIC	0	0	0	0	0	194.22
194.23 07973 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.23
194.24 07974 SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.25 07975 HENNEPIN CLINIC	0	0	0	0	0	194.25
194.26 07976 FAMILY HEALTH CENTER 2ND FLOOR	0	0	0	0	0	194.26
194.27 07977 MIDTOWN	0	0	0	0	0	194.27
194.28 07978 PAIN CLINIC	0	0	0	0	0	194.28
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	1,504,710	1,334,816	128,170	2,002,787	36	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/27/2013 9:29 am			
Cost Center Description		Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		2A	4.00	5.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS	5,449	5,449			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,290,477	517	1,290,994		5.00
7.00	00700	OPERATION OF PLANT	234,413	93	63,235	297,741	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,913	7	5,685	1,446	11,051
9.00	00900	HOUSEKEEPING	18,559	92	18,876	5,772	0
10.00	01000	DIETARY	63,334	67	14,295	14,853	0
11.00	01100	CAFETERIA	13,353	130	20,093	4,936	0
13.00	01300	NURSING ADMINISTRATION	16,410	192	27,627	5,735	0
16.00	01600	MEDICAL RECORDS & LIBRARY	48,171	310	49,736	7,640	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	257,689	636	100,919	47,557	7,186
31.00	03100	INTENSIVE CARE UNIT	106,948	149	25,234	9,280	589
43.00	04300	NURSERY	11,538	19	3,480	2,224	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	842,438	491	249,957	29,429	1,171
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,575	93	14,799	1,120	0
53.00	05300	ANESTHESIOLOGY	99,286	0	7,428	1,127	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	504,844	198	66,433	13,416	737
54.01	05402	NUCLEAR MEDICINE	6,212	24	10,949	2,288	0
57.00	05700	CT SCAN	308,667	33	17,234	1,184	147
60.00	06000	LABORATORY	78,412	217	87,448	7,120	6
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,117	0	10,492	426	0
65.00	06500	RESPIRATORY THERAPY	44,825	105	17,780	2,131	22
66.00	06600	PHYSICAL THERAPY	76,645	275	40,407	18,909	589
67.00	06700	OCCUPATIONAL THERAPY	192	27	4,908	71	0
68.00	06800	SPEECH PATHOLOGY	1,718	16	2,335	321	0
69.00	06900	ELECTROCARDIOLOGY	34,397	29	5,585	240	0
70.00	07000	ELECTROENCEPHALOGRAPHY	25,384	15	3,145	3,847	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	195,544	10	14,379	13,744	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	41,329	165	54,391	3,861	0
76.00	03020	SONOGRAPHY	29,976	38	9,891	974	0
76.01	03021	AUDIOLOGY	0	0	6,366	0	0
76.02	03022	CARDIAC REHAB	20,527	38	6,144	2,716	0
76.03	03023	ECP	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
90.00	09000	CLINIC	288,768	988	212,948	30,889	0
91.00	09100	EMERGENCY	69,441	175	41,543	10,023	589
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	4	12,039	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	36,678	82	18,607	1,774	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,801,229	5,235	1,244,388	245,053	11,036
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,578	0	186	2,431	0
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0
194.01	07951	CONGREGATE LIVING	65,407	7	2,890	24,176	0
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0
194.03	07953	MANAGED CARE	0	14	2,153	0	0
194.04	07954	RENTAL AREA/PPOS	56,271	0	1,587	20,799	0
194.05	07955	SPECIALTY CLINICS	0	0	35	0	15
194.06	07956	LASALLE SELLETT SUITE	0	0	0	0	0
194.07	07957	LASALLE STANMAR SUITE	0	0	0	0	0
194.08	07958	ENT	0	0	0	0	0
194.09	07959	DURABLE MEDICAL EQUIPMENT	15,330	49	14,195	5,282	0
194.10	07960	PERU MALL	0	0	0	0	0
194.11	07961	LADD	0	0	0	0	0
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0
194.14	07964	HENRY	0	0	0	0	0
194.15	07965	LAMOILLE	0	0	0	0	0
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140143

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
194.17	07967	OGLESBY MP OB	0	0	0	0	0	0 194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	0 194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	0 194.19
194.20	07970	PARATRANSIT	22,627	28	5,808	0	0	0 194.20
194.21	07971	OCCUPATIONAL HEALTH	3,077	113	19,256	0	0	0 194.21
194.22	07972	SPORTS MEDICINE CLINIC	0	0	0	0	0	0 194.22
194.23	07973	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	0 194.23
194.24	07974	SURGICAL ASSOCIATES	0	0	0	3	0	0 194.24
194.25	07975	HENNEPIN CLINIC	0	0	0	0	0	0 194.25
194.26	07976	FAMILY HEALTH CENTER 2ND FLOOR	0	0	0	0	0	0 194.26
194.27	07977	MIDTOWN	0	0	0	0	0	0 194.27
194.28	07978	PAIN CLINIC	0	3	493	0	0	0 194.28
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	4,970,519	5,449	1,290,994	297,741	11,051	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140143		Period: From 10/01/2011 To 09/30/2012		Worksheet B Part II Date/Time Prepared: 2/27/2013 9:29 am	
Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
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	43,299					9.00
10.00	01000	DIETARY	2,139	94,688				10.00
11.00	01100	CAFETERIA	1,710	0	40,222			11.00
13.00	01300	NURSING ADMINISTRATION	1,286	0	1,588	52,838		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,601	0	5,031	0	113,489	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,608	64,737	9,293	25,049	6,384	30.00
31.00	03100	INTENSIVE CARE UNIT	2,129	8,495	1,673	4,509	1,045	31.00
43.00	04300	NURSERY	195	0	380	1,022	328	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,442	6,677	5,672	15,288	20,766	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	862	0	783	2,112	475	52.00
53.00	05300	ANESTHESIOLOGY	34	0	0	0	3,696	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,279	0	2,389	0	7,410	54.00
54.01	05402	NUCLEAR MEDICINE	77	0	228	0	1,420	54.01
57.00	05700	CT SCAN	77	0	324	0	8,166	57.00
60.00	06000	LABORATORY	862	0	2,953	0	15,049	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	90	0	0	0	478	63.00
65.00	06500	RESPIRATORY THERAPY	207	0	1,104	0	2,331	65.00
66.00	06600	PHYSICAL THERAPY	428	0	0	0	4,839	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	574	67.00
68.00	06800	SPEECH PATHOLOGY	77	0	0	0	168	68.00
69.00	06900	ELECTROCARDIOLOGY	134	0	308	0	2,108	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30	0	216	0	509	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	207	0	233	0	6,146	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	862	0	1,310	0	4,212	73.00
76.00	03020	SONOGRAPHY	77	0	336	0	2,846	76.00
76.01	03021	AUDIOLOGY	77	0	0	0	295	76.01
76.02	03022	CARDIAC REHAB	0	0	0	0	514	76.02
76.03	03023	ECP	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	2,400	0	3,479	90.00
91.00	09100	EMERGENCY	862	0	1,803	4,858	4,206	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	302	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	1,005	0	1,454	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	36,352	79,909	39,029	52,838	99,200	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	77	0	0	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	3,225	194.00
194.01	07951	CONGREGATE LIVING	0	14,779	124	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	1,379	194.02
194.03	07953	MANAGED CARE	0	0	156	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	6,870	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	0	210	194.05
194.06	07956	LASALLE SELLETT SUITE	0	0	0	0	0	194.06
194.07	07957	LASALLE STANMAR SUITE	0	0	0	0	0	194.07
194.08	07958	ENT	0	0	0	0	1,086	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	0	370	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.11	07961	LADD	0	0	0	0	0	194.11
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	2,077	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	1,680	194.13
194.14	07964	HENRY	0	0	0	0	105	194.14
194.15	07965	LAMOILLE	0	0	0	0	0	194.15

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140143

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

Worksheet B
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Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
	9.00	10.00	11.00	13.00	16.00	
194.16 07966 SPRING VALLEY CLINIC	0	0	0	0	356	194.16
194.17 07967 OGLESBY MP OB	0	0	0	0	199	194.17
194.18 07968 FAMILY HEALTH CENTER	0	0	0	0	791	194.18
194.19 07969 GRANVILLE CLINIC	0	0	0	0	259	194.19
194.20 07970 PARATRANSIT	0	0	0	0	0	194.20
194.21 07971 OCCUPATIONAL HEALTH	0	0	913	0	230	194.21
194.22 07972 SPORTS MEDICINE CLINIC	0	0	0	0	0	194.22
194.23 07973 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.23
194.24 07974 SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.25 07975 HENNEPIN CLINIC	0	0	0	0	0	194.25
194.26 07976 FAMILY HEALTH CENTER 2ND FLOOR	0	0	0	0	720	194.26
194.27 07977 MIDTOWN	0	0	0	0	1,600	194.27
194.28 07978 PAIN CLINIC	0	0	0	0	2	194.28
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)	43,299	94,688	40,222	52,838	113,489	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/27/2013 9:29 am		
Cost Center	Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP				2.01
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
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	536,058	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	160,051	0	31.00
43.00	04300	NURSERY	0	19,186	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,175,331	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	43,819	0	52.00
53.00	05300	ANESTHESIOLOGY	0	111,571	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	596,706	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	21,198	0	54.01
57.00	05700	CT SCAN	0	335,832	0	57.00
60.00	06000	LABORATORY	0	192,067	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	13,603	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	68,505	0	65.00
66.00	06600	PHYSICAL THERAPY	0	142,092	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,772	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,635	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	42,801	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	33,146	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	230,263	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	106,130	0	73.00
76.00	03020	SONOGRAPHY	0	44,138	0	76.00
76.01	03021	AUDIOLOGY	0	6,738	0	76.01
76.02	03022	CARDIAC REHAB	0	29,939	0	76.02
76.03	03023	ECP	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
90.00	09000	CLINIC	0	539,472	0	90.00
91.00	09100	EMERGENCY	0	133,500	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	12,345	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
116.00	11600	HOSPICE	0	59,600	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,664,498	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,272	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	3,225	0	194.00
194.01	07951	CONGREGATE LIVING	0	107,383	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	1,379	0	194.02
194.03	07953	MANAGED CARE	0	2,323	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	85,527	0	194.04
194.05	07955	SPECIALTY CLINICS	0	260	0	194.05
194.06	07956	LASALLE SELLETT SUITE	0	0	0	194.06
194.07	07957	LASALLE STANMAR SUITE	0	0	0	194.07
194.08	07958	ENT	0	1,086	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	35,226	0	194.09
194.10	07960	PERU MALL	0	0	0	194.10
194.11	07961	LADD	0	0	0	194.11
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	2,077	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	1,680	0	194.13

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140143

Period:
From 10/01/2011
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
194.14	07964 HENRY	0	105	0	105		194.14
194.15	07965 LAMOLLE	0	0	0	0		194.15
194.16	07966 SPRING VALLEY CLINIC	0	356	0	356		194.16
194.17	07967 OGLESBY MP OB	0	199	0	199		194.17
194.18	07968 FAMILY HEALTH CENTER	0	791	0	791		194.18
194.19	07969 GRANVILLE CLINIC	0	259	0	259		194.19
194.20	07970 PARATRANSIT	0	28,463	0	28,463		194.20
194.21	07971 OCCUPATIONAL HEALTH	0	23,589	0	23,589		194.21
194.22	07972 SPORTS MEDICINE CLINIC	0	0	0	0		194.22
194.23	07973 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.23
194.24	07974 SURGICAL ASSOCIATES	0	3	0	3		194.24
194.25	07975 HENNEPIN CLINIC	0	0	0	0		194.25
194.26	07976 FAMILY HEALTH CENTER 2ND FLOOR	0	720	0	720		194.26
194.27	07977 MIDTOWN	0	1,600	0	1,600		194.27
194.28	07978 PAIN CLINIC	0	498	0	498		194.28
200.00	Cross Foot Adjustments	0	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	0	4,970,519	0	4,970,519		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140143

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

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Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS (GROSS SALARY)	
		NEW BLDG & FIXT (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OLD MVBLE EQUIP (DOLLAR VALUE)		
		1.00	1.01	2.00	2.01		
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	296,906				1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	0	296,906			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			1,958,022		2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP			0	36	2.01
4.00	00400	EMPLOYEE BENEFITS	1,106	1,106	0	0	21,553,764
5.00	00500	ADMINISTRATIVE & GENERAL	101,643	101,643	602,013	36	2,042,876
7.00	00700	OPERATION OF PLANT	30,681	30,681	80,549	0	367,467
8.00	00800	LAUNDRY & LINEN SERVICE	794	794	0	0	28,409
9.00	00900	HOUSEKEEPING	3,169	3,169	306	0	364,894
10.00	01000	DIETARY	8,155	8,155	22,634	0	263,447
11.00	01100	CAFETERIA	2,710	2,710	0	0	515,290
13.00	01300	NURSING ADMINISTRATION	3,149	3,149	874	0	759,886
16.00	01600	MEDICAL RECORDS & LIBRARY	4,195	4,195	26,885	0	1,226,009
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,112	26,112	110,849	0	2,514,850
31.00	03100	INTENSIVE CARE UNIT	5,095	5,095	9,768	0	590,890
43.00	04300	NURSERY	1,221	1,221	5,399	0	76,564
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,158	16,158	497,678	0	1,940,534
52.00	05200	DELIVERY ROOM & LABOR ROOM	615	615	20,086	0	368,730
53.00	05300	ANESTHESIOLOGY	619	619	30,089	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,366	7,366	114,501	0	782,916
54.01	05402	NUCLEAR MEDICINE	1,256	1,256	22	0	96,437
57.00	05700	CT SCAN	650	650	764	0	130,764
60.00	06000	LABORATORY	3,909	3,909	57,829	0	859,552
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	234	234	942	0	0
65.00	06500	RESPIRATORY THERAPY	1,170	1,170	28,663	0	413,824
66.00	06600	PHYSICAL THERAPY	10,382	10,382	10,092	0	1,086,061
67.00	06700	OCCUPATIONAL THERAPY	39	39	0	0	105,224
68.00	06800	SPEECH PATHOLOGY	176	176	832	0	65,184
69.00	06900	ELECTROCARDIOLOGY	132	132	10,479	0	115,745
70.00	07000	ELECTROENCEPHALOGRAPHY	2,112	2,112	14,642	0	58,560
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,546	7,546	29,133	0	39,478
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,120	2,120	9,228	0	651,485
76.00	03020	SONOGRAPHY	535	535	26,729	0	150,571
76.01	03021	AUDIOLOGY	0	0	0	0	0
76.02	03022	CARDIAC REHAB	1,491	1,491	12,885	0	150,131
76.03	03023	ECP	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
90.00	09000	CLINIC	16,960	16,960	200,613	0	3,914,550
91.00	09100	EMERGENCY	5,503	5,503	5,979	0	693,401
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	14,193
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
114.00	11400	UTILIZATION REVIEW-SNF					
116.00	11600	HOSPICE	974	974	1,413	0	325,398
118.00		SUBTOTALS (SUM OF LINES 1-117)	267,977	267,977	1,931,876	36	20,713,320
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,335	1,335	0	0	0
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0
194.01	07951	CONGREGATE LIVING	13,274	13,274	0	0	26,430
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICINE	0	0	0	0	0
194.03	07953	MANAGED CARE	0	0	0	0	53,892
194.04	07954	RENTAL AREA/PPOS	11,420	11,420	0	0	0
194.05	07955	SPECIALTY CLINICS	0	0	0	0	16
194.06	07956	LASALLE SELLETT SUITE	0	0	0	0	0
194.07	07957	LASALLE STANMAR SUITE	0	0	0	0	0
194.08	07958	ENT	0	0	0	0	0
194.09	07959	DURABLE MEDICAL EQUIPMENT	2,900	2,900	1,017	0	191,720
194.10	07960	PERU MALL	0	0	0	0	0
194.11	07961	LADD	0	0	0	0	0
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140143

Period:
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Cost Center Description	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS (GROSS SALARY)	
	NEW BLDG & FIXT (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OLD MVBLE EQUIP (DOLLAR VALUE)		
	1.00	1.01	2.00	2.01		
194.13 07963 WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14 07964 HENRY	0	0	0	0	0	194.14
194.15 07965 LAMOILLE	0	0	0	0	0	194.15
194.16 07966 SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17 07967 OGLESBY MP OB	0	0	0	0	0	194.17
194.18 07968 FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19 07969 GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20 07970 PARATRANSIT	0	0	22,121	0	110,262	194.20
194.21 07971 OCCUPATIONAL HEALTH	0	0	3,008	0	445,284	194.21
194.22 07972 SPORTS MEDICINE CLINIC	0	0	0	0	0	194.22
194.23 07973 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.23
194.24 07974 SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.25 07975 HENNEPIN CLINIC	0	0	0	0	0	194.25
194.26 07976 FAMILY HEALTH CENTER 2ND FLOOR	0	0	0	0	0	194.26
194.27 07977 MIDTOWN	0	0	0	0	0	194.27
194.28 07978 PAIN CLINIC	0	0	0	0	12,840	194.28
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1,334,816	128,170	2,002,787	36	4,883,259	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	4.495753	0.431685	1.022862	1.000000	0.226562	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)					5,449	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)					0.000253	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140143

Period:
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Date/Time Prepared:
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Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,500,112	45,761,643			5.00
7.00	00700	OPERATION OF PLANT	0	2,241,519	163,476		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	201,534	794	284,555	8.00
9.00	00900	HOUSEKEEPING	0	669,110	3,169	0	38,023
10.00	01000	DIETARY	0	506,702	8,155	0	1,878
11.00	01100	CAFETERIA	0	712,240	2,710	0	1,502
13.00	01300	NURSING ADMINISTRATION	0	979,309	3,149	0	1,129
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,763,004	4,195	0	2,284
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	3,577,278	26,112	185,053	14,581
31.00	03100	INTENSIVE CARE UNIT	0	894,491	5,095	15,167	1,870
43.00	04300	NURSERY	0	123,343	1,221	0	171
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	8,859,824	16,158	30,163	3,023
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	524,575	615	0	757
53.00	05300	ANESTHESIOLOGY	0	263,316	619	0	30
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,354,873	7,366	18,980	1,123
54.01	05402	NUCLEAR MEDICINE	0	388,101	1,256	0	68
57.00	05700	CT SCAN	0	610,899	650	3,785	68
60.00	06000	LABORATORY	0	3,099,791	3,909	142	757
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	371,927	234	0	79
65.00	06500	RESPIRATORY THERAPY	0	630,251	1,170	556	182
66.00	06600	PHYSICAL THERAPY	0	1,432,301	10,382	15,167	376
67.00	06700	OCCUPATIONAL THERAPY	0	173,961	39	0	0
68.00	06800	SPEECH PATHOLOGY	0	82,762	176	0	68
69.00	06900	ELECTROCARDIOLOGY	0	197,965	132	0	118
70.00	07000	ELECTROENCEPHALOGRAPHY	0	111,490	2,112	0	26
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	509,682	7,546	0	182
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,928,005	2,120	0	757
76.00	03020	SONOGRAPHY	0	350,599	535	0	68
76.01	03021	AUDIOLOGY	0	225,640	0	0	68
76.02	03022	CARDIAC REHAB	0	217,779	1,491	0	0
76.03	03023	ECP	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
90.00	09000	CLINIC	0	7,548,412	16,960	0	0
91.00	09100	EMERGENCY	0	1,472,589	5,503	15,167	757
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	426,746	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	659,551	974	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,500,112	44,109,569	134,547	284,180	31,922
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,578	1,335	0	68
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0
194.01	07951	CONGREGATE LIVING	0	102,455	13,274	0	0
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0
194.03	07953	MANAGED CARE	0	76,310	0	0	0
194.04	07954	RENTAL AREA/PPOS	0	56,271	11,420	0	6,033
194.05	07955	SPECIALTY CLINICS	0	1,225	0	375	0
194.06	07956	LASALLE SELLETT SUITE	0	0	0	0	0
194.07	07957	LASALLE STANMAR SUITE	0	0	0	0	0
194.08	07958	ENT	0	0	0	0	0
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	503,182	2,900	0	0
194.10	07960	PERU MALL	0	0	0	0	0
194.11	07961	LADD	0	0	0	0	0
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0
194.14	07964	HENRY	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140143

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

Worksheet B-1

Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5A	5.00	7.00	8.00	9.00	
194.15	07965 LAMOILLE	0	0	0	0	0	194.15
194.16	07966 SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967 OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968 FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969 GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970 PARATRANSIT	0	205,885	0	0	0	194.20
194.21	07971 OCCUPATIONAL HEALTH	0	682,576	0	0	0	194.21
194.22	07972 SPORTS MEDICINE CLINIC	0	0	0	0	0	194.22
194.23	07973 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.23
194.24	07974 SURGICAL ASSOCIATES	0	111	0	0	0	194.24
194.25	07975 HENNEPIN CLINIC	0	0	0	0	0	194.25
194.26	07976 FAMILY HEALTH CENTER 2ND FLOOR	0	0	0	0	0	194.26
194.27	07977 MIDTOWN	0	0	0	0	0	194.27
194.28	07978 PAIN CLINIC	0	17,481	0	0	0	194.28
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)		8,500,112	2,657,877	251,878	844,919	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)		0.185748	16.258515	0.885165	22.221261	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		1,290,994	297,741	11,051	43,299	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.028211	1.821313	0.038836	1.138758	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140143

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

Worksheet B-1

Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (PATIENT CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
2.01	00201						2.01
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	30,363					11.00
13.00	01300	0	25,728				13.00
16.00	01600	0	1,016	260,837			16.00
17.00	01700	0	3,218	0	167,006,538		17.00
		0	0	0	0	607	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	20,759	5,945	123,656	9,388,054	556	30.00
31.00	03100	2,724	1,070	22,259	1,537,176	0	31.00
43.00	04300	0	243	5,046	482,550	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,141	3,628	75,468	30,652,540	0	50.00
52.00	05200	0	501	10,427	699,018	0	52.00
53.00	05300	0	0	0	5,435,209	0	53.00
54.00	05400	0	1,528	0	10,897,611	0	54.00
54.01	05402	0	146	0	2,088,307	0	54.01
57.00	05700	0	207	0	12,008,091	0	57.00
60.00	06000	0	1,889	0	22,131,479	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	0	0	703,236	0	63.00
65.00	06500	0	706	0	3,427,247	0	65.00
66.00	06600	0	0	0	7,116,185	0	66.00
67.00	06700	0	0	0	843,545	0	67.00
68.00	06800	0	0	0	247,307	0	68.00
69.00	06900	0	197	0	3,099,309	0	69.00
70.00	07000	0	138	0	747,945	0	70.00
71.00	07100	0	149	0	9,038,623	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	838	0	6,194,276	0	73.00
76.00	03020	0	215	0	4,184,816	0	76.00
76.01	03021	0	0	0	433,100	0	76.01
76.02	03022	0	0	0	755,321	0	76.02
76.03	03023	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
90.00	09000	0	1,535	0	5,115,472	0	90.00
91.00	09100	0	1,153	23,981	6,184,905	51	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	444,217	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
116.00	11600	0	643	0	2,138,287	0	116.00
118.00		25,624	24,965	260,837	145,993,826	607	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	4,742,737	0	194.00
194.01	07951	4,739	79	0	0	0	194.01
194.02	07952	0	0	0	2,028,587	0	194.02
194.03	07953	0	100	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	308,159	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	1,596,941	0	194.08
194.09	07959	0	0	0	543,891	0	194.09
194.10	07960	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
194.12	07962	0	0	0	3,054,516	0	194.12
194.13	07963	0	0	0	2,470,175	0	194.13

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140143

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

Worksheet B-1

Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (PATIENT CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		10.00	11.00	13.00	16.00	17.00	
194.14	07964 HENRY	0	0	0	154,829	0	194.14
194.15	07965 LAMOLLE	0	0	0	0	0	194.15
194.16	07966 SPRING VALLEY CLINIC	0	0	0	524,181	0	194.16
194.17	07967 OGLESBY MOB	0	0	0	292,178	0	194.17
194.18	07968 FAMILY HEALTH CENTER	0	0	0	1,163,875	0	194.18
194.19	07969 GRANVILLE CLINIC	0	0	0	380,276	0	194.19
194.20	07970 PARATRANSIT	0	0	0	0	0	194.20
194.21	07971 OCCUPATIONAL HEALTH	0	584	0	338,323	0	194.21
194.22	07972 SPORTS MEDICINE CLINIC	0	0	0	0	0	194.22
194.23	07973 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.23
194.24	07974 SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.25	07975 HENNEPIN CLINIC	0	0	0	0	0	194.25
194.26	07976 FAMILY HEALTH CENTER 2ND FLOOR	0	0	0	1,058,346	0	194.26
194.27	07977 MIDTOWN	0	0	0	2,352,829	0	194.27
194.28	07978 PAIN CLINIC	0	0	0	2,869	0	194.28
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)	775,141	921,974	1,273,909	2,324,753	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	25.529131	35.835432	4.883928	0.013920	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	94,688	40,222	52,838	113,489	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.118532	1.563355	0.202571	0.000680	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140143

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

Worksheet C
Part I
Date/Time Prepared:
2/27/2013 9:29 am

		Title XVIII		Hospital		PPS		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
				Total Costs	RCE Disallowance			
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,631,719		6,631,719	0	6,631,719	30.00
31.00	03100	INTENSIVE CARE UNIT	1,436,450		1,436,450	0	1,436,450	31.00
43.00	04300	NURSERY	209,975		209,975	0	209,975	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,842,032		11,842,032	0	11,842,032	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	727,443		727,443	0	727,443	52.00
53.00	05300	ANESTHESIOLOGY	398,615		398,615	61,280	459,895	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,160,252		3,160,252	0	3,160,252	54.00
54.01	05402	NUCLEAR MEDICINE	516,423		516,423	0	516,423	54.01
57.00	05700	CT SCAN	914,372		914,372	0	914,372	57.00
60.00	06000	LABORATORY	4,131,836		4,131,836	0	4,131,836	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	456,360		456,360	0	456,360	63.00
65.00	06500	RESPIRATORY THERAPY	843,884	0	843,884	0	843,884	65.00
66.00	06600	PHYSICAL THERAPY	1,987,981	0	1,987,981	0	1,987,981	66.00
67.00	06700	OCCUPATIONAL THERAPY	218,650	0	218,650	0	218,650	67.00
68.00	06800	SPEECH PATHOLOGY	105,950	0	105,950	0	105,950	68.00
69.00	06900	ELECTROCARDIOLOGY	289,707		289,707	0	289,707	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	182,471		182,471	0	182,471	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	862,242		862,242	0	862,242	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,453,671		2,453,671	0	2,453,671	73.00
76.00	03020	SONOGRAPHY	491,889		491,889	0	491,889	76.00
76.01	03021	AUDIOLOGY	275,092		275,092	0	275,092	76.01
76.02	03022	CARDIAC REHAB	292,986		292,986	0	292,986	76.02
76.03	03023	ECP	0		0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	9,352,472		9,352,472	0	9,352,472	90.00
91.00	09100	EMERGENCY	2,110,369		2,110,369	328,865	2,439,234	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,228,895		1,228,895	0	1,228,895	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	512,197		512,197	0	512,197	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	850,704		850,704		850,704	116.00
200.00		Subtotal (see instructions)	52,484,637	0	52,484,637	390,145	52,874,782	200.00
201.00		Less Observation Beds	1,228,895		1,228,895		1,228,895	201.00
202.00		Total (see instructions)	51,255,742	0	51,255,742	390,145	51,645,887	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140143

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

Worksheet C
Part I
Date/Time Prepared:
2/27/2013 9:29 am

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 VIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,412,265		7,412,265		30.00
31.00	03100	INTENSIVE CARE UNIT	1,530,672		1,530,672		31.00
43.00	04300	NURSERY	477,638		477,638		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,583,845	19,816,419	30,400,264	0.389537	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	610,385	82,720	693,105	1.049542	52.00
53.00	05300	ANESTHESIOLOGY	1,746,386	3,642,161	5,388,547	0.073974	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,408,856	9,412,144	10,821,000	0.292048	54.00
54.01	05402	NUCLEAR MEDICINE	210,423	1,862,391	2,072,814	0.249141	54.01
57.00	05700	CT SCAN	2,328,920	9,592,113	11,921,033	0.076702	57.00
60.00	06000	LABORATORY	5,860,366	16,137,889	21,998,255	0.187826	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	470,219	230,595	700,814	0.651186	63.00
65.00	06500	RESPIRATORY THERAPY	2,742,398	673,821	3,416,219	0.247023	65.00
66.00	06600	PHYSICAL THERAPY	868,868	6,206,944	7,075,812	0.280954	66.00
67.00	06700	OCCUPATIONAL THERAPY	104,938	734,932	839,870	0.260338	67.00
68.00	06800	SPEECH PATHOLOGY	34,176	210,418	244,594	0.433167	68.00
69.00	06900	ELECTROCARDIOLOGY	1,645,555	1,442,691	3,088,246	0.093810	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,129	736,846	737,975	0.247259	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,445,321	2,561,900	9,007,221	0.095728	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,314,278	2,830,351	6,144,629	0.399320	73.00
76.00	03020	SONOGRAPHY	1,066,576	3,090,190	4,156,766	0.118335	76.00
76.01	03021	AUDIOLOGY	0	433,100	433,100	0.635170	76.01
76.02	03022	CARDIAC REHAB	42,438	706,929	749,367	0.390978	76.02
76.03	03023	ECP	0	0	0	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	43,000	5,015,425	5,058,425	1.848890	90.00
91.00	09100	EMERGENCY	1,503,317	4,648,797	6,152,114	0.343032	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	339,511	1,597,724	1,937,235	0.634355	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	442,112	442,112	1.158523	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	2,138,069	2,138,069		116.00
200.00		Subtotal (see instructions)	50,791,480	94,246,681	145,038,161		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	50,791,480	94,246,681	145,038,161		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/27/2013 9:29 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.389537		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.049542		52.00
53.00	05300 ANESTHESIOLOGY	0.085347		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.292048		54.00
54.01	05402 NUCLEAR MEDICINE	0.249141		54.01
57.00	05700 CT SCAN	0.076702		57.00
60.00	06000 LABORATORY	0.187826		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.651186		63.00
65.00	06500 RESPIRATORY THERAPY	0.247023		65.00
66.00	06600 PHYSICAL THERAPY	0.280954		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.260338		67.00
68.00	06800 SPEECH PATHOLOGY	0.433167		68.00
69.00	06900 ELECTROCARDIOLOGY	0.093810		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.247259		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.095728		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.399320		73.00
76.00	03020 SONOGRAPHY	0.118335		76.00
76.01	03021 AUDIOLOGY	0.635170		76.01
76.02	03022 CARDIAC REHAB	0.390978		76.02
76.03	03023 ECP	0.000000		76.03
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC			88.00
90.00	09000 CLINIC	1.848890		90.00
91.00	09100 EMERGENCY	0.396487		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.634355		92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	1.158523		95.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140143

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

Worksheet C
Part I
Date/Time Prepared:
2/27/2013 9:29 am

		Title XIX		Hospital		PPS		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
				Total Costs	RCE Disallowance			
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,631,719		6,631,719	0	6,631,719	30.00
31.00	03100	INTENSIVE CARE UNIT	1,436,450		1,436,450	0	1,436,450	31.00
43.00	04300	NURSERY	209,975		209,975	0	209,975	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,842,032		11,842,032	0	11,842,032	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	727,443		727,443	0	727,443	52.00
53.00	05300	ANESTHESIOLOGY	398,615		398,615	61,280	459,895	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,160,252		3,160,252	0	3,160,252	54.00
54.01	05402	NUCLEAR MEDICINE	516,423		516,423	0	516,423	54.01
57.00	05700	CT SCAN	914,372		914,372	0	914,372	57.00
60.00	06000	LABORATORY	4,131,836		4,131,836	0	4,131,836	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	456,360		456,360	0	456,360	63.00
65.00	06500	RESPIRATORY THERAPY	843,884	0	843,884	0	843,884	65.00
66.00	06600	PHYSICAL THERAPY	1,987,981	0	1,987,981	0	1,987,981	66.00
67.00	06700	OCCUPATIONAL THERAPY	218,650	0	218,650	0	218,650	67.00
68.00	06800	SPEECH PATHOLOGY	105,950	0	105,950	0	105,950	68.00
69.00	06900	ELECTROCARDIOLOGY	289,707		289,707	0	289,707	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	182,471		182,471	0	182,471	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	862,242		862,242	0	862,242	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,453,671		2,453,671	0	2,453,671	73.00
76.00	03020	SONOGRAPHY	491,889		491,889	0	491,889	76.00
76.01	03021	AUDIOLOGY	275,092		275,092	0	275,092	76.01
76.02	03022	CARDIAC REHAB	292,986		292,986	0	292,986	76.02
76.03	03023	ECP	0		0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	9,352,472		9,352,472	0	9,352,472	90.00
91.00	09100	EMERGENCY	2,110,369		2,110,369	328,865	2,439,234	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,228,895		1,228,895	0	1,228,895	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	512,197		512,197	0	512,197	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	850,704		850,704		850,704	116.00
200.00		Subtotal (see instructions)	52,484,637	0	52,484,637	390,145	52,874,782	200.00
201.00		Less Observation Beds	1,228,895		1,228,895		1,228,895	201.00
202.00		Total (see instructions)	51,255,742	0	51,255,742	390,145	51,645,887	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140143		Period: From 10/01/2011 To 09/30/2012		Worksheet C Part I Date/Time Prepared: 2/27/2013 9:29 am	
			Title XIX		Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,412,265		7,412,265			30.00
31.00	03100	INTENSIVE CARE UNIT	1,530,672		1,530,672			31.00
43.00	04300	NURSERY	477,638		477,638			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,583,845	19,816,419	30,400,264	0.389537	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	610,385	82,720	693,105	1.049542	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,746,386	3,642,161	5,388,547	0.073974	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,408,856	9,412,144	10,821,000	0.292048	0.000000	54.00
54.01	05402	NUCLEAR MEDICINE	210,423	1,862,391	2,072,814	0.249141	0.000000	54.01
57.00	05700	CT SCAN	2,328,920	9,592,113	11,921,033	0.076702	0.000000	57.00
60.00	06000	LABORATORY	5,860,366	16,137,889	21,998,255	0.187826	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	470,219	230,595	700,814	0.651186	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	2,742,398	673,821	3,416,219	0.247023	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	868,868	6,206,944	7,075,812	0.280954	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	104,938	734,932	839,870	0.260338	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	34,176	210,418	244,594	0.433167	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,645,555	1,442,691	3,088,246	0.093810	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,129	736,846	737,975	0.247259	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,445,321	2,561,900	9,007,221	0.095728	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,314,278	2,830,351	6,144,629	0.399320	0.000000	73.00
76.00	03020	SONOGRAPHY	1,066,576	3,090,190	4,156,766	0.118335	0.000000	76.00
76.01	03021	AUDIOLOGY	0	433,100	433,100	0.635170	0.000000	76.01
76.02	03022	CARDIAC REHAB	42,438	706,929	749,367	0.390978	0.000000	76.02
76.03	03023	ECP	0	0	0	0.000000	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
90.00	09000	CLINIC	43,000	5,015,425	5,058,425	1.848890	0.000000	90.00
91.00	09100	EMERGENCY	1,503,317	4,648,797	6,152,114	0.343032	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	339,511	1,597,724	1,937,235	0.634355	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	442,112	442,112	1.158523	0.000000	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	2,138,069	2,138,069			116.00
200.00		Subtotal (see instructions)	50,791,480	94,246,681	145,038,161			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	50,791,480	94,246,681	145,038,161			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/27/2013 9:29 am
		Title XIX	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
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.389537	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.049542	52.00
53.00	05300	ANESTHESIOLOGY	0.085347	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.292048	54.00
54.01	05402	NUCLEAR MEDICINE	0.249141	54.01
57.00	05700	CT SCAN	0.076702	57.00
60.00	06000	LABORATORY	0.187826	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.651186	63.00
65.00	06500	RESPIRATORY THERAPY	0.247023	65.00
66.00	06600	PHYSICAL THERAPY	0.280954	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.260338	67.00
68.00	06800	SPEECH PATHOLOGY	0.433167	68.00
69.00	06900	ELECTROCARDIOLOGY	0.093810	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.247259	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.095728	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.399320	73.00
76.00	03020	SONOGRAPHY	0.118335	76.00
76.01	03021	AUDIOLOGY	0.635170	76.01
76.02	03022	CARDIAC REHAB	0.390978	76.02
76.03	03023	ECP	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
90.00	09000	CLINIC	1.848890	90.00
91.00	09100	EMERGENCY	0.396487	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.634355	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	1.158523	95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140143

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

Worksheet C Part II Date/Time Prepared: 2/27/2013 9:29 am

Cost Center Description		Title XIX			Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,842,032	1,175,331	10,666,701	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	727,443	43,819	683,624	0	0	52.00
53.00	05300	ANESTHESIOLOGY	398,615	111,571	287,044	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,160,252	596,706	2,563,546	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	516,423	21,198	495,225	0	0	54.01
57.00	05700	CT SCAN	914,372	335,832	578,540	0	0	57.00
60.00	06000	LABORATORY	4,131,836	192,067	3,939,769	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	456,360	13,603	442,757	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	843,884	68,505	775,379	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,987,981	142,092	1,845,889	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	218,650	5,772	212,878	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	105,950	4,635	101,315	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	289,707	42,801	246,906	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	182,471	33,146	149,325	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	862,242	230,263	631,979	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,453,671	106,130	2,347,541	0	0	73.00
76.00	03020	SONOGRAPHY	491,889	44,138	447,751	0	0	76.00
76.01	03021	AUDIOLOGY	275,092	6,738	268,354	0	0	76.01
76.02	03022	CARDIAC REHAB	292,986	29,939	263,047	0	0	76.02
76.03	03023	ECP	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	9,352,472	539,472	8,813,000	0	0	90.00
91.00	09100	EMERGENCY	2,110,369	133,500	1,976,869	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,228,895	100,762	1,128,133	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	512,197	12,345	499,852	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	850,704	59,600	791,104	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	44,206,493	4,049,965	40,156,528	0	0	200.00
201.00		Less Observation Beds	1,228,895	100,762	1,128,133	0	0	201.00
202.00		Total (line 200 minus line 201)	42,977,598	3,949,203	39,028,395	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140143

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

Worksheet C Part II Date/Time Prepared: 2/27/2013 9:29 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	11,842,032	30,400,264	0.389537	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	727,443	693,105	1.049542	52.00
53.00	05300 ANESTHESIOLOGY	398,615	5,388,547	0.073974	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,160,252	10,821,000	0.292048	54.00
54.01	05402 NUCLEAR MEDICINE	516,423	2,072,814	0.249141	54.01
57.00	05700 CT SCAN	914,372	11,921,033	0.076702	57.00
60.00	06000 LABORATORY	4,131,836	21,998,255	0.187826	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	456,360	700,814	0.651186	63.00
65.00	06500 RESPIRATORY THERAPY	843,884	3,416,219	0.247023	65.00
66.00	06600 PHYSICAL THERAPY	1,987,981	7,075,812	0.280954	66.00
67.00	06700 OCCUPATIONAL THERAPY	218,650	839,870	0.260338	67.00
68.00	06800 SPEECH PATHOLOGY	105,950	244,594	0.433167	68.00
69.00	06900 ELECTROCARDIOLOGY	289,707	3,088,246	0.093810	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	182,471	737,975	0.247259	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	862,242	9,007,221	0.095728	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,453,671	6,144,629	0.399320	73.00
76.00	03020 SONOGRAPHY	491,889	4,156,766	0.118335	76.00
76.01	03021 AUDIOLOGY	275,092	433,100	0.635170	76.01
76.02	03022 CARDIAC REHAB	292,986	749,367	0.390978	76.02
76.03	03023 ECP	0	0	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	88.00
90.00	09000 CLINIC	9,352,472	5,058,425	1.848890	90.00
91.00	09100 EMERGENCY	2,110,369	6,152,114	0.343032	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,228,895	1,937,235	0.634355	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	512,197	442,112	1.158523	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
114.00	11400 UTILIZATION REVIEW-SNF				114.00
116.00	11600 HOSPICE	850,704	2,138,069	0.397884	116.00
200.00	Subtotal (sum of lines 50 thru 199)	44,206,493	135,617,586		200.00
201.00	Less Observation Beds	1,228,895	0		201.00
202.00	Total (line 200 minus line 201)	42,977,598	135,617,586		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 140143		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part I Date/Time Prepared: 2/27/2013 9:29 am	
Cost Center Description			Title XVIII		Hospital		PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	536,058	7,594	528,464	8,411	62.83	30.00
31.00	03100	INTENSIVE CARE UNIT	160,051		160,051	839	190.76	31.00
43.00	04300	NURSERY	19,186		19,186	577	33.25	43.00
200.00		Total (lines 30-199)	715,295		707,701	9,827		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140143		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part I Date/Time Prepared: 2/27/2013 9:29 am	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XVIII	Hospital	PPS	
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,503	282,923			30.00
31.00	03100	INTENSIVE CARE UNIT	525	100,149			31.00
43.00	04300	NURSERY	0	0			43.00
200.00		Total (lines 30-199)	5,028	383,072			200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part II Date/Time Prepared: 2/27/2013 9:29 am
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Cost Center Description		Title XVIII			Hospital		PPS	
		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	1,175,331	30,400,264	0.038662	4,983,661	192,678	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	43,819	693,105	0.063221	6,333	400	52.00
53.00	05300	ANESTHESIOLOGY	111,571	5,388,547	0.020705	779,943	16,149	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	596,706	10,821,000	0.055143	1,269,537	70,006	54.00
54.01	05402	NUCLEAR MEDICINE	21,198	2,072,814	0.010227	130,979	1,340	54.01
57.00	05700	CT SCAN	335,832	11,921,033	0.028171	1,395,407	39,310	57.00
60.00	06000	LABORATORY	192,067	21,998,255	0.008731	3,955,484	34,535	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	13,603	700,814	0.019410	345,771	6,711	63.00
65.00	06500	RESPIRATORY THERAPY	68,505	3,416,219	0.020053	1,718,544	34,462	65.00
66.00	06600	PHYSICAL THERAPY	142,092	7,075,812	0.020081	534,885	10,741	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,772	839,870	0.006872	57,821	397	67.00
68.00	06800	SPEECH PATHOLOGY	4,635	244,594	0.018950	28,630	543	68.00
69.00	06900	ELECTROCARDIOLOGY	42,801	3,088,246	0.013859	1,289,266	17,868	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	33,146	737,975	0.044915	1,029	46	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	230,263	9,007,221	0.025564	4,175,769	106,749	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	106,130	6,144,629	0.017272	2,182,638	37,699	73.00
76.00	03020	SONOGRAPHY	44,138	4,156,766	0.010618	434,788	4,617	76.00
76.01	03021	AUDIOLOGY	6,738	433,100	0.015558	0	0	76.01
76.02	03022	CARDIAC REHAB	29,939	749,367	0.039952	0	0	76.02
76.03	03023	ECP	0	0	0.000000	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	539,472	5,058,425	0.106648	40,923	4,364	90.00
91.00	09100	EMERGENCY	133,500	6,152,114	0.021700	1,469,751	31,894	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	100,762	1,937,235	0.052013	46,315	2,409	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	3,978,020	133,037,405		24,847,474	612,918	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140143		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/27/2013 9:29 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140143		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/27/2013 9:29 am	
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	8,411	0.00	4,503	0	30.00	
31.00	03100 INTENSIVE CARE UNIT	839	0.00	525	0	31.00	
43.00	04300 NURSERY	577	0.00	0	0	43.00	
200.00	Total (lines 30-199)	9,827		5,028	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/27/2013 9:29 am
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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	
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	
54.01	05402	NUCLEAR MEDICINE	0	0	0	0	54.01	
57.00	05700	CT SCAN	0	0	0	0	57.00	
60.00	06000	LABORATORY	0	0	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	
76.00	03020	SONOGRAPHY	0	0	0	0	76.00	
76.01	03021	AUDIOLOGY	0	0	0	0	76.01	
76.02	03022	CARDIAC REHAB	0	0	0	0	76.02	
76.03	03023	ECP	0	0	0	0	76.03	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00	
90.00	09000	CLINIC	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00	
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00	
200.00		Total (Lines 50-199)	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/27/2013 9:29 am
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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)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	30,400,264	0.000000	0.000000	4,983,661	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	693,105	0.000000	0.000000	6,333	52.00
53.00	05300	ANESTHESIOLOGY	0	5,388,547	0.000000	0.000000	779,943	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,821,000	0.000000	0.000000	1,269,537	54.00
54.01	05402	NUCLEAR MEDICINE	0	2,072,814	0.000000	0.000000	130,979	54.01
57.00	05700	CT SCAN	0	11,921,033	0.000000	0.000000	1,395,407	57.00
60.00	06000	LABORATORY	0	21,998,255	0.000000	0.000000	3,955,484	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	700,814	0.000000	0.000000	345,771	63.00
65.00	06500	RESPIRATORY THERAPY	0	3,416,219	0.000000	0.000000	1,718,544	65.00
66.00	06600	PHYSICAL THERAPY	0	7,075,812	0.000000	0.000000	534,885	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	839,870	0.000000	0.000000	57,821	67.00
68.00	06800	SPEECH PATHOLOGY	0	244,594	0.000000	0.000000	28,630	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,088,246	0.000000	0.000000	1,289,266	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	737,975	0.000000	0.000000	1,029	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,007,221	0.000000	0.000000	4,175,769	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,144,629	0.000000	0.000000	2,182,638	73.00
76.00	03020	SONOGRAPHY	0	4,156,766	0.000000	0.000000	434,788	76.00
76.01	03021	AUDIOLOGY	0	433,100	0.000000	0.000000	0	76.01
76.02	03022	CARDIAC REHAB	0	749,367	0.000000	0.000000	0	76.02
76.03	03023	ECP	0	0	0.000000	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	5,058,425	0.000000	0.000000	40,923	90.00
91.00	09100	EMERGENCY	0	6,152,114	0.000000	0.000000	1,469,751	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,937,235	0.000000	0.000000	46,315	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	133,037,405			24,847,474	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/27/2013 9:29 am
	Title XVIII	Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	5,160,940	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	592	0	52.00
53.00	05300 ANESTHESIOLOGY	0	1,049,398	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	3,756,483	0	54.00
54.01	05402 NUCLEAR MEDICINE	0	892,648	0	54.01
57.00	05700 CT SCAN	0	3,253,589	0	57.00
60.00	06000 LABORATORY	0	282,044	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	128,577	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	390,806	0	65.00
66.00	06600 PHYSICAL THERAPY	0	3,782	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	384	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	681,016	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	3,087	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,160,571	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,658,290	0	73.00
76.00	03020 SONOGRAPHY	0	659,017	0	76.00
76.01	03021 AUDIOLOGY	0	62,386	0	76.01
76.02	03022 CARDIAC REHAB	0	56,692	0	76.02
76.03	03023 ECP	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
90.00	09000 CLINIC	0	1,026,477	0	90.00
91.00	09100 EMERGENCY	0	2,555,038	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	389,048	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (Lines 50-199)	0	23,170,865	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/27/2013 9:29 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS	
		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	0.389537	5,160,940	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.049542	592	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.073974	1,049,398	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.292048	3,756,483	0	0	54.00
54.01	05402 NUCLEAR MEDICINE	0.249141	892,648	0	0	54.01
57.00	05700 CT SCAN	0.076702	3,253,589	0	0	57.00
60.00	06000 LABORATORY	0.187826	282,044	891	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.651186	128,577	92	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.247023	390,806	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.280954	3,782	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.260338	384	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.433167	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.093810	681,016	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.247259	3,087	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.095728	1,160,571	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.399320	1,658,290	0	27,662	73.00
76.00	03020 SONOGRAPHY	0.118335	659,017	0	0	76.00
76.01	03021 AUDIOLOGY	0.635170	62,386	0	0	76.01
76.02	03022 CARDIAC REHAB	0.390978	56,692	0	0	76.02
76.03	03023 ECP	0.000000	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
90.00	09000 CLINIC	1.848890	1,026,477	0	0	90.00
91.00	09100 EMERGENCY	0.343032	2,555,038	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.634355	389,048	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1.158523		0		95.00
200.00	Subtotal (see instructions)		23,170,865	983	27,662	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		23,170,865	983	27,662	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/27/2013 9:29 am
		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	2,010,377	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	621	0	0	52.00
53.00	05300 ANESTHESIOLOGY	77,628	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,097,073	0	0	54.00
54.01	05402 NUCLEAR MEDICINE	222,395	0	0	54.01
57.00	05700 CT SCAN	249,557	0	0	57.00
60.00	06000 LABORATORY	52,975	167	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	83,728	60	0	63.00
65.00	06500 RESPIRATORY THERAPY	96,538	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,063	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	100	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	63,886	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	763	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	111,099	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	662,188	0	11,046	73.00
76.00	03020 SONOGRAPHY	77,985	0	0	76.00
76.01	03021 AUDIOLOGY	39,626	0	0	76.01
76.02	03022 CARDIAC REHAB	22,165	0	0	76.02
76.03	03023 ECP	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
90.00	09000 CLINIC	1,897,843	0	0	90.00
91.00	09100 EMERGENCY	876,460	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	246,795	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES		0		95.00
200.00	Subtotal (see instructions)	7,890,865	227	11,046	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00	Net Charges (line 200 +/- line 201)	7,890,865	227	11,046	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 140143		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part I Date/Time Prepared: 2/27/2013 9:29 am	
Cost Center Description			Title XIX		Hospital		PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	536,058	7,594	528,464	8,411	62.83	30.00
31.00	03100	INTENSIVE CARE UNIT	160,051		160,051	839	190.76	31.00
43.00	04300	NURSERY	19,186		19,186	577	33.25	43.00
200.00		Total (lines 30-199)	715,295		707,701	9,827		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140143		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part I Date/Time Prepared: 2/27/2013 9:29 am	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XIX Hospital		PPS	
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	556	34,933			30.00
31.00	03100	INTENSIVE CARE UNIT	47	8,966			31.00
43.00	04300	NURSERY	275	9,144			43.00
200.00		Total (lines 30-199)	878	53,043			200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part II Date/Time Prepared: 2/27/2013 9:29 am
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Cost Center Description		Title XIX			Hospital	PPS
		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	1,175,331	30,400,264	0.038662	0	0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	43,819	693,105	0.063221	0	0 52.00
53.00	05300 ANESTHESIOLOGY	111,571	5,388,547	0.020705	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	596,706	10,821,000	0.055143	0	0 54.00
54.01	05402 NUCLEAR MEDICINE	21,198	2,072,814	0.010227	0	0 54.01
57.00	05700 CT SCAN	335,832	11,921,033	0.028171	0	0 57.00
60.00	06000 LABORATORY	192,067	21,998,255	0.008731	0	0 60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0 60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	13,603	700,814	0.019410	0	0 63.00
65.00	06500 RESPIRATORY THERAPY	68,505	3,416,219	0.020053	0	0 65.00
66.00	06600 PHYSICAL THERAPY	142,092	7,075,812	0.020081	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	5,772	839,870	0.006872	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	4,635	244,594	0.018950	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	42,801	3,088,246	0.013859	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	33,146	737,975	0.044915	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	230,263	9,007,221	0.025564	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	106,130	6,144,629	0.017272	0	0 73.00
76.00	03020 SONOGRAPHY	44,138	4,156,766	0.010618	0	0 76.00
76.01	03021 AUDIOLOGY	6,738	433,100	0.015558	0	0 76.01
76.02	03022 CARDIAC REHAB	29,939	749,367	0.039952	0	0 76.02
76.03	03023 ECP	0	0	0.000000	0	0 76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0 88.00
90.00	09000 CLINIC	539,472	5,058,425	0.106648	0	0 90.00
91.00	09100 EMERGENCY	133,500	6,152,114	0.021700	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	100,762	1,937,235	0.052013	0	0 92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0 93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	3,978,020	133,037,405		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140143		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/27/2013 9:29 am	
Cost Center Description			Title XIX		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	
43.00	04300	NURSERY	0	0	0	0	0	
200.00		Total (lines 30-199)	0	0	0	0	0	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140143		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/27/2013 9:29 am	
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	8,411	0.00	556	0	30.00
31.00	03100	INTENSIVE CARE UNIT	839	0.00	47	0	31.00
43.00	04300	NURSERY	577	0.00	275	0	43.00
200.00		Total (lines 30-199)	9,827		878	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/27/2013 9:29 am
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Cost Center Description	Title XIX				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	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 05402 NUCLEAR MEDICINE	0	0	0	0	0	54.01
57.00 05700 CT SCAN	0	0	0	0	0	57.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03020 SONOGRAPHY	0	0	0	0	0	76.00
76.01 03021 AUDIOLOGY	0	0	0	0	0	76.01
76.02 03022 CARDIAC REHAB	0	0	0	0	0	76.02
76.03 03023 ECP	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00 Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140143

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

Worksheet D
Part IV
Date/Time Prepared:
2/27/2013 9:29 am

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)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	30,400,264	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	693,105	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	5,388,547	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,821,000	0.000000	0.000000	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	2,072,814	0.000000	0.000000	0	54.01
57.00	05700	CT SCAN	0	11,921,033	0.000000	0.000000	0	57.00
60.00	06000	LABORATORY	0	21,998,255	0.000000	0.000000	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	700,814	0.000000	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	3,416,219	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,075,812	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	839,870	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	244,594	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,088,246	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	737,975	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,007,221	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,144,629	0.000000	0.000000	0	73.00
76.00	03020	SONOGRAPHY	0	4,156,766	0.000000	0.000000	0	76.00
76.01	03021	AUDIOLOGY	0	433,100	0.000000	0.000000	0	76.01
76.02	03022	CARDIAC REHAB	0	749,367	0.000000	0.000000	0	76.02
76.03	03023	ECP	0	0	0.000000	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	5,058,425	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	6,152,114	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,937,235	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	133,037,405			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/27/2013 9:29 am
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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)	Hospital	PPS
Title XIX						
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05402 NUCLEAR MEDICINE	0	0	0		54.01
57.00	05700 CT SCAN	0	0	0		57.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020 SONOGRAPHY	0	0	0		76.00
76.01	03021 AUDIOLOGY	0	0	0		76.01
76.02	03022 CARDIAC REHAB	0	0	0		76.02
76.03	03023 ECP	0	0	0		76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (Lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 2/27/2013 9:29 am
Cost Center Description		PPS		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,901	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,411	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.		2,227	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,603	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		123	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)		367	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		4,503	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)		115	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)		344	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		188.27	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		192.90	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)		6,631,719	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		23,157	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)		70,794	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)		93,951	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,537,768	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		7,922,317	28.00
29.00	Private room charges (excluding swing-bed charges)		3,009,640	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		4,912,677	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.825234	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		1,351.43	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,067.28	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		284.15	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		234.49	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		522,209	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,015,559	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)		777.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,500,137	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)		3,500,137	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140143		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 2/27/2013 9:29 am	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,436,450	839	1,712.10	525	898,853		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)					6,227,058		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,626,048		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)					383,072		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					612,918		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					995,990		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					9,630,058		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)					21,651		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					66,358		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					88,009		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)					1,581		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					777.29		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,228,895		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140143		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/27/2013 9:29 am	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	536,058	6,537,768	0.081994	1,228,895	100,762	90.00
91.00	Nursing School cost	0	6,537,768	0.000000	1,228,895	0	91.00
92.00	Allied health cost	0	6,537,768	0.000000	1,228,895	0	92.00
93.00	All other Medical Education	0	6,537,768	0.000000	1,228,895	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1 Date/Time Prepared: 2/27/2013 9:29 am
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,901	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,411	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)		6,830	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		123	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)		367	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)		556	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)		577	15.00
16.00	Nursery days (title V or XIX only)		275	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		188.27	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		192.90	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)		6,631,719	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		23,157	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)		70,794	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)		93,951	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,537,768	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	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)		6,537,768	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)		777.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		432,173	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)		432,173	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140143		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1	
Title XIX		Hospital		PPS		Date/Time Prepared: 2/27/2013 9:29 am	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	209,975	577	363.91	275	100,075		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,436,450	839	1,712.10	47	80,469		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						612,717	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)						53,043	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						53,043	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						559,674	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)						1,581	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						777.29	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						1,228,895	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140143		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/27/2013 9:29 am	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	536,058	6,537,768	0.081994	1,228,895	100,762	90.00
91.00	Nursing School cost	0	6,537,768	0.000000	1,228,895	0	91.00
92.00	Allied health cost	0	6,537,768	0.000000	1,228,895	0	92.00
93.00	All other Medical Education	0	6,537,768	0.000000	1,228,895	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/27/2013 9:29 am	
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		4,573,305	30.00
31.00	03100	INTENSIVE CARE UNIT		1,002,055	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.389537	4,983,661	1,941,320 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.049542	6,333	6,647 52.00
53.00	05300	ANESTHESIOLOGY	0.085347	779,943	66,566 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.292048	1,269,537	370,766 54.00
54.01	05402	NUCLEAR MEDICINE	0.249141	130,979	32,632 54.01
57.00	05700	CT SCAN	0.076702	1,395,407	107,031 57.00
60.00	06000	LABORATORY	0.187826	3,955,484	742,943 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.651186	345,771	225,161 63.00
65.00	06500	RESPIRATORY THERAPY	0.247023	1,718,544	424,520 65.00
66.00	06600	PHYSICAL THERAPY	0.280954	534,885	150,278 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.260338	57,821	15,053 67.00
68.00	06800	SPEECH PATHOLOGY	0.433167	28,630	12,402 68.00
69.00	06900	ELECTROCARDIOLOGY	0.093810	1,289,266	120,946 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.247259	1,029	254 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.095728	4,175,769	399,738 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.399320	2,182,638	871,571 73.00
76.00	03020	SONOGRAPHY	0.118335	434,788	51,451 76.00
76.01	03021	AUDIOLOGY	0.635170	0	0 76.01
76.02	03022	CARDIAC REHAB	0.390978	0	0 76.02
76.03	03023	ECP	0.000000	0	0 76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
90.00	09000	CLINIC	1.848890	40,923	75,662 90.00
91.00	09100	EMERGENCY	0.396487	1,469,751	582,737 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.634355	46,315	29,380 92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0 93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			
200.00		Total (sum of lines 50-94 and 96-98)		24,847,474	6,227,058 200.00
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)		24,847,474	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3	
		Component CCN: 14U143		Date/Time Prepared: 2/27/2013 9:29 am	
		Title XVIII	Swing Beds - SNF	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
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.389537	16,107	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.049542	71	52.00
53.00	05300	ANESTHESIOLOGY	0.073974	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.292048	34,118	54.00
54.01	05402	NUCLEAR MEDICINE	0.249141	2,033	54.01
57.00	05700	CT SCAN	0.076702	6,311	57.00
60.00	06000	LABORATORY	0.187826	110,301	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.651186	5,686	63.00
65.00	06500	RESPIRATORY THERAPY	0.247023	107,550	65.00
66.00	06600	PHYSICAL THERAPY	0.280954	89,610	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.260338	8,806	67.00
68.00	06800	SPEECH PATHOLOGY	0.433167	3,826	68.00
69.00	06900	ELECTROCARDIOLOGY	0.093810	3,619	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.247259	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.095728	258,545	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.399320	177,593	73.00
76.00	03020	SONOGRAPHY	0.118335	4,042	76.00
76.01	03021	AUDIOLOGY	0.635170	0	76.01
76.02	03022	CARDIAC REHAB	0.390978	0	76.02
76.03	03023	ECP	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	1.848890	1,504	90.00
91.00	09100	EMERGENCY	0.343032	13	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.634355	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		829,735	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)		829,735	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part A Date/Time Prepared: 2/27/2013 9:29 am
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		7,180,002	1.00
2.00	Outlier payments for discharges. (see instructions)		48,543	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)		63.34	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)		0.00	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		0.00	31.00
32.00	Sum of lines 30 and 31		0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	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)		7,228,545	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		8,531,146	48.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part A Date/Time Prepared: 2/27/2013 9:29 am
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		8,205,496	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		560,545	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).		0	57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		8,766,041	59.00
60.00	Primary payer payments		2,410	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		8,763,631	61.00
62.00	Deductibles billed to program beneficiaries		1,034,304	62.00
63.00	Coinsurance billed to program beneficiaries		2,294	63.00
64.00	Allowable bad debts (see instructions)		115,215	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		80,651	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		83,723	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		7,807,684	67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0	68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.95	Recovery of Accelerated Depreciation		0	70.95
70.96	Low Volume Payment-1		0	70.96
70.97	Low Volume Payment-2		0	70.97
70.98	Low Volume Payment-3		0	70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,807,684	71.00
72.00	Interim payments		8,025,620	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)		-217,936	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		131,000	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: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/27/2013 9:29 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		11,273	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		7,890,865	2.00
3.00	PPS payments		6,381,437	3.00
4.00	Outlier payment (see instructions)		156,417	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.799	5.00
6.00	Line 2 times line 5		6,304,801	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		11,273	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		28,645	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)		28,645	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)		28,645	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		17,372	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)		11,273	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)		6,537,854	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)		1,539,331	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)		5,009,796	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)		5,009,796	30.00
31.00	Primary payer payments		114	31.00
32.00	Subtotal (line 30 minus line 31)		5,009,682	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)		189,354	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		132,548	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		155,120	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		5,142,230	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)		5,142,230	40.00
41.00	Interim payments		5,476,111	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		-333,881	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140143

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

Worksheet E-1
Part I
Date/Time Prepared:
2/27/2013 9:29 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		8,497,488		5,017,952		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		493,414		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	05/29/2012	451,951	05/29/2012	24,555		3.50
3.51		09/19/2012	19,917	09/19/2012	10,700		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)		-471,868		-35,255		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)		8,025,620		5,476,111		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		217,936		333,881		6.02
7.00	Total Medicare program liability (see instructions)		7,807,684		5,142,230		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: 140143
Component CCN: 14U143

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

Worksheet E-1
Part I
Date/Time Prepared:
2/27/2013 9:29 am

Title XVIII Swing Beds - SNF 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		124,783		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)		124,783		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		425		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		125,208		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 140143
Component CCN: 14U143

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

Worksheet E-2
Date/Time Prepared:
2/27/2013 9:29 am

		Title XVIII		Swing Beds - SNF	
		PPS			
		Part A	Part B		
		1.00	2.00		
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	138,267	0	1.00	
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00	
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)			3.00	
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00	
5.00	Program days	459	0	5.00	
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00	
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00	
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	138,267	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	138,267	0	10.00	
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00	
12.00	Subtotal (line 10 minus line 11)	138,267	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	13,484	0	13.00	
14.00	80% of Part B costs (line 12 x 80%)		0	14.00	
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	124,783	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00	
17.00	Reimbursable bad debts (see instructions)	425	0	17.00	
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	425	0	18.00	
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	125,208	0	19.00	
20.00	Interim payments	124,783	0	20.00	
21.00	Tentative settlement (for contractor use only)	0	0	21.00	
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	425	0	22.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00	

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

Provider CCN: 140143

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

Worksheet G

Date/Time Prepared:
2/27/2013 9:29 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,227,079	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	41,342,520	0	0	0	4.00
5.00	Other receivable	207,348	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-28,590,465	0	0	0	6.00
7.00	Inventory	1,877,773	0	0	0	7.00
8.00	Prepaid expenses	500,901	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)	16,565,156	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,464,302	0	0	0	12.00
13.00	Land improvements	2,319,264	0	0	0	13.00
14.00	Accumulated depreciation	-1,453,477	0	0	0	14.00
15.00	Buildings	50,955,827	0	0	0	15.00
16.00	Accumulated depreciation	-26,995,328	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	21,967,131	0	0	0	23.00
24.00	Accumulated depreciation	-16,231,203	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	33,026,516	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	15,680,654	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	3,453,832	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	19,134,486	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	68,726,158	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	7,417,721	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,772,409	0	0	0	38.00
39.00	Payroll taxes payable	247,792	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,407,487	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	181,044	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,026,453	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	9,995,339	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	680,002	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,675,341	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,701,794	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	46,024,364				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	46,024,364	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	68,726,158	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140143

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

Worksheet G-1

Date/Time Prepared:
2/27/2013 9:29 am

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
1.00	Fund balances at beginning of period		42,859,381		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,726,015			2.00
3.00	Total (sum of line 1 and line 2)		45,585,396		0	3.00
4.00	CONTRIBUTIONS	484,889		0		4.00
5.00	CHANGE IN FOUNDATION INTEREST	5,523		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)		490,412		0	10.00
11.00	Subtotal (line 3 plus line 10)		46,075,808		0	11.00
12.00	EQUITY TRANSFER	51,444		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)		51,444		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		46,024,364		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140143

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

Worksheet G-1

Date/Time Prepared:
2/27/2013 9:29 am

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00 Fund balances at beginning of period		0		0		1.00
2.00 Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00 Total (sum of line 1 and line 2)		0		0		3.00
4.00 CONTRIBUTIONS	0		0			4.00
5.00 CHANGE IN FOUNDATION INTEREST	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 EQUITY TRANSFER	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: 140143

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	7,922,317		7,922,317	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,922,317		7,922,317	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,688,436		2,688,436	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)	2,688,436		2,688,436	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,610,753		10,610,753	17.00
18.00	Ancillary services	40,902,346	91,997,970	132,900,316	18.00
19.00	Outpatient services	0	20,936,331	20,936,331	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	444,217	444,217	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	2,138,287	2,138,287	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	51,513,099	115,516,805	167,029,904	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		68,439,547		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)		68,439,547		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140143

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

Worksheet G-3

Date/Time Prepared:
2/27/2013 9:29 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	167,029,904	1.00
2.00	Less contractual allowances and discounts on patients' accounts	99,063,744	2.00
3.00	Net patient revenues (line 1 minus line 2)	67,966,160	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	68,439,547	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-473,387	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	25	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	181,816	14.00
15.00	Revenue from rental of living quarters	110,236	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	334,595	17.00
18.00	Revenue from sale of medical records and abstracts	20,494	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	103,781	22.00
23.00	Governmental appropriations	0	23.00
24.00	CHANGE IN EQUITY GAINS AND LOSSES	-46,535	24.00
24.01		0	24.01
24.02		0	24.02
24.03	OTHER REVENUE	91,805	24.03
24.04	PARATRANSIT	175,155	24.04
24.05	OUTSIDE REHABILITATION SERVICES	67,760	24.05
24.06	CONTRIBUTIONS SPENT FOR OPERATIONS	293,557	24.06
24.07	INVESTMENT INCOME	2,000,491	24.07
25.00	Total other income (sum of lines 6-24)	3,333,180	25.00
26.00	Total (line 5 plus line 25)	2,859,793	26.00
27.00	NET RENTAL LOSS	6,235	27.00
27.01	LOSS ON DISPOSAL OF EQUIPMENT	127,543	27.01
27.02		0	27.02
27.03		0	27.03
27.04		0	27.04
27.05		0	27.05
28.00	Total other expenses (sum of line 27 and subscripts)	133,778	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,726,015	29.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140143

Period: From 10/01/2011

Worksheet K

Hospice CCN: 141595

To 09/30/2012

Date/Time Prepared: 2/27/2013 9:29 am

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	5,863	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	12,000	9.00
10.00	Nursing Care	245,211	0	9,788	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	52,634	0	1,944	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	27,553	0	4,570	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	13,751	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	6,884	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	166,057	33,329	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)	325,398	0	16,302	166,057	71,827	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140143

Period: From 10/01/2011

Worksheet K

Hospice CCN: 141595

To 09/30/2012

Date/Time Prepared: 2/27/2013 9:29 am

		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	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	5,863	0	5,863	0	5,863	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	12,000	0	12,000	0	12,000	9.00
10.00	Nursing Care	254,999	0	254,999	0	254,999	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	54,578	0	54,578	0	54,578	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	32,123	0	32,123	0	32,123	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	13,751	0	13,751	0	13,751	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	6,884	0	6,884	0	6,884	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	199,386	0	199,386	0	199,386	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)	579,584	0	579,584	0	579,584	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140143

Period: From 10/01/2011

Worksheet K-1

Hospice CCN: 141595

To 09/30/2012

Date/Time Prepared: 2/27/2013 9:29 am

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	27,715	217,496	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	52,634	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	52,634	27,715	217,496	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140143

Period:

Worksheet K-1

Hospice CCN: 141595

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

Date/Time Prepared:
2/27/2013 9:29 am

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	0	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	245,211	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	52,634	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		27,553	0	27,553	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	27,553	0	325,398	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet K-3
		Hospice CCN: 141595		Date/Time Prepared: 2/27/2013 9:29 am

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	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						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES	Provider CCN: 140143 Hospice CCN: 141595	Period: From 10/01/2011 To 09/30/2012	Worksheet K-3 Date/Time Prepared: 2/27/2013 9:29 am
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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	0	0	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	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	166,057	166,057	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	166,057	166,057	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140143
 Hospice CCN: 141595

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

Worksheet K-4
 Part I
 Date/Time Prepared:
 2/27/2013 9:29 am

		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	5,863	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	12,000	0	0	0	0	9.00
10.00	Nursing Care	254,999	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	54,578	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	32,123	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	13,751	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	6,884	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	199,386	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)	579,584	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140143

Period:

Worksheet K-4

Hospice CCN: 141595

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

Part I
Date/Time Prepared:
2/27/2013 9:29 am

		Hospice I			
	VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col . 5A ± col . 6)	
	5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.				1.00
2.00	Capital Related Costs-Movable Equip.				2.00
3.00	Plant Operation and Maintenance				3.00
4.00	Transportation - Staff				4.00
5.00	Volunteer Service Coordination	0			5.00
6.00	Administrative and General	0	5,863	5,863	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	12,000	123	12,123
10.00	Nursing Care	0	254,999	2,605	257,604
11.00	Nursing Care-Continuous Home Care	0	0	0	11.00
12.00	Physical Therapy	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	14.00
15.00	Medical Social Services	0	54,578	558	55,136
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	32,123	328	32,451
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	0	13,751	141	13,892
23.00	Analgesics	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	24.00
25.00	Other - Specify	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	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	6,884	70	6,954
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	199,386	2,038	201,424
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	579,584		579,584

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140143

Period: From 10/01/2011

Worksheet K-4

Hospice CCN: 141595

To 09/30/2012

Part II
Date/Time Prepared:
2/27/2013 9:29 am

		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: 140143
 Hospice CCN: 141595

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

Worksheet K-4
 Part II
 Date/Time Prepared:
 2/27/2013 9:29 am

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	Hospice I
		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	-5,863	573,721	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	12,000	9.00
10.00	Nursing Care	0	254,999	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	54,578	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	32,123	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	13,751	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	6,884	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	199,386	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)		5,863	39.00
40.00	Unit Cost Multiplier		0.010219	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140143

Period: From 10/01/2011

Worksheet K-5

Hospice CCN: 141595

To 09/30/2012

Part I
Date/Time Prepared:
2/27/2013 9:29 am

Hospice I

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
		1.00	1.01	2.00	2.01	
1.00 Administrative and General	0	4,379	420	1,445	0	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	12,123	0	0	0	0	4.00
5.00 Nursing Care	257,604	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	55,136	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	32,451	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	13,892	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	6,954	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	201,424	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)	579,584	4,379	420	1,445	0	34.00
35.00 Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140143

Period:

Worksheet K-5

Hospice CCN: 141595

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

Part I
Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		4.00	4A	5.00	7.00	8.00	
1.00	Administrative and General	0	6,244	1,160	15,836	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	12,123	2,252	0	0	4.00
5.00	Nursing Care	55,556	313,160	58,169	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	11,925	67,061	12,456	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	6,242	38,693	7,187	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	13,892	2,580	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 - Specif y	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	6,954	1,292	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	201,424	37,414	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)	73,723	659,551	122,510	15,836	0	34.00
35.00	Unit Cost Multiplier (see instructions)		0.000000				35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140143

Period: From 10/01/2011

Worksheet K-5

Hospice CCN: 141595

To 09/30/2012

Part I
Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description	Hospice I					MEDICAL RECORDS & LIBRARY	
	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION			
	9.00	10.00	11.00	13.00	16.00		
1.00 Administrative and General	0	0	0	0	29,765	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	15,874	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	3,584	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	3,584	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	23,042	0	29,765	0	34.00
35.00 Unit Cost Multiplier (see instructions)							35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140143

Period: From 10/01/2011

Worksheet K-5

Hospice CCN: 141595

To 09/30/2012

Part I
Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description		Hospice I					Allocated Hospice A&G (See Part II)
		SOCIAL SERVICE	Subtotal (col.s. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (col.s. 24 ± 25)		
		17.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	53,005				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	14,375	0	14,375	955	4.00
5.00	Nursing Care	0	387,203	0	387,203	25,728	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	83,101	0	83,101	5,522	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	49,464	0	49,464	3,287	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	16,472	0	16,472	1,095	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	8,246	0	8,246	548	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	238,838	0	238,838	15,870	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	850,704	0	850,704		34.00
35.00	Unit Cost Multiplier (see instructions)					0.066447	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140143

Period:

Worksheet K-5

Hospice CCN: 141595

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

Part I
Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description		Total Hospice Costs (cols. 26 ± 27)	Hospice I	
		28.00		
1.00	Administrative and General			1.00
2.00	Inpatient - General Care	0		2.00
3.00	Inpatient - Respite Care	0		3.00
4.00	Physician Services	15,330		4.00
5.00	Nursing Care	412,931		5.00
6.00	Nursing Care-Continuous Home Care	0		6.00
7.00	Physical Therapy	0		7.00
8.00	Occupational Therapy	0		8.00
9.00	Speech/ Language Pathology	0		9.00
10.00	Medical Social Services	88,623		10.00
11.00	Spiritual Counseling	0		11.00
12.00	Dietary Counseling	0		12.00
13.00	Counseling - Other	0		13.00
14.00	Home Health Aide and Homemaker	52,751		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0		15.00
16.00	Other	0		16.00
17.00	Drugs, Biological and Infusion Therapy	17,567		17.00
18.00	Analgesics	0		18.00
19.00	Sedatives / Hypnotics	0		19.00
20.00	Other - Specify	0		20.00
21.00	Durable Medical Equipment/Oxygen	0		21.00
22.00	Patient Transportation	0		22.00
23.00	Imaging Services	0		23.00
24.00	Labs and Diagnostics	0		24.00
25.00	Medical Supplies	8,794		25.00
26.00	Outpatient Services (including E/R Dept.)	0		26.00
27.00	Radiation Therapy	0		27.00
28.00	Chemotherapy	0		28.00
29.00	Other	254,708		29.00
30.00	Bereavement Program Costs	0		30.00
31.00	Volunteer Program Costs	0		31.00
32.00	Fundraising	0		32.00
33.00	Other Program Costs	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	850,704		34.00
35.00	Unit Cost Multiplier (see instructions)			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140143
Hospice CCN: 141595

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

Worksheet K-5
Part II
Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS (GROSS SALARY)	
		NEW BLDG & FIXT (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OLD MVBLE EQUIP (DOLLAR VALUE)		
		1.00	1.01	2.00	2.01		
1.00	Administrative and General	974	974	1,413	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	245,211	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	52,634	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	27,553	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)	974	974	1,413	0	325,398	34.00
35.00	Total cost to be allocated	4,379	420	1,445	0	73,723	35.00
36.00	Unit Cost Multiplier (see instructions)	4.495893	0.431211	1.022647	0.000000	0.226563	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140143
Hospice CCN: 141595

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

Worksheet K-5
Part II
Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description	Reconciliation	Hospice I				
		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
	5A	5.00	7.00	8.00	9.00	
1.00 Administrative and General	0	6,244	974	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	12,123	0	0	0	4.00
5.00 Nursing Care	0	313,160	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	67,061	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	38,693	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	13,892	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	6,954	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	201,424	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)		659,551	974	0	0	34.00
35.00 Total cost to be allocated		122,510	15,836	0	0	35.00
36.00 Unit Cost Multiplier (see instructions)		0.185748	16.258727	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140143
Hospice CCN: 141595

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

Worksheet K-5
Part II
Date/Time Prepared:
2/27/2013 9:29 am

Cost Center Description	Hospice I					SOCIAL SERVICE (TIME SPENT)	
	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (PATIENT CHARGES)			
	10.00	11.00	13.00	16.00	17.00		
1.00 Administrative and General	0	0	0	2,138,287	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	443	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	100	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	100	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	643	0	2,138,287	0	34.00	
35.00 Total cost to be allocated	0	23,042	0	29,765	0	35.00	
36.00 Unit Cost Multiplier (see instructions)	0.000000	35.835148	0.000000	0.013920	0.000000	36.00	

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet K-5 Part III Date/Time Prepared: 2/27/2013 9:29 am	
		Hospice CCN: 141595	Hospice I		
Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
	0	1.00	2.00	3.00	
ANCI LLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.280954	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.260338	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.433167	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.399320	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00			5.00
6.00	LABORATORY	60.00	0.187826	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.095728	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00	0.000000	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00			9.00
10.00	SONOGRAPHY	76.00	0.118335	0	10.00
10.01	AUDIOLOGY	76.01	0.635170	0	10.01
10.02	CARDIAC REHAB	76.02	0.390978	0	10.02
10.03	ECP	76.03	0.000000	0	10.03
11.00	Totals (sum of lines 1-10)				11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 140143

Period: From 10/01/2011

Worksheet K-6

Hospice CCN: 141595

To 09/30/2012

Date/Time Prepared: 2/27/2013 9:29 am

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				850,704	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				6,140	2.00
3.00	Average cost per diem (line 1 divided by line 2)				138.55	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	6,132				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	849,589				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		2			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		277			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			6		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			831		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140143	Period: From 10/01/2011 To 09/30/2012	Worksheet L Parts I-III Date/Time Prepared: 2/27/2013 9:29 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		555,125	1.00
2.00	Capital DRG outlier payments		5,420	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		21.05	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)		560,545	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