

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	Worksheet S Parts I-III Date/Time Prepared: 2/28/2014 2:17 pm
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PART I - COST REPORT STATUS

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

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

Date: 2/28/2014 Time: 2:17 pm

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BLESSING HOSPITAL (140015) for the cost reporting period beginning 10/01/2012 and ending 09/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 2/28/2014 Time: 2:17 pm
 3I5k0Nh2sw.XaIZNF5LyLZJ0REWx0
 JhJo40gerMmgDgewWZcSIBfHpENPG
 u7YY1t2:970NANho
 PI: Date: 2/28/2014 Time: 2:17 pm
 o8QxAEBqb2rfYTF3uj2u1pc2Uipb.0
 atNj203yfJNTB6jH3Pqfoi1Pit007y
 MYMc0gHkxz0XhYyp

(Signed)

 officer or Administrator of Provider(s)

 Title

 Date

Line Item	Description	Title XVIII					Total
		Part A	Part B	Part C	Part D	Part E	
1.00	Hospital	0	-174,905	-157,797	1,298,611	0	1.00
2.00	Subprovider - IPF	0	159,452	0	0	0	2.00
3.00	Subprovider - IRF	0	28,652	0	0	0	3.00
5.00	Swing bed - SNF	0	0	0	0	0	5.00
6.00	Swing bed - NF	0	0	0	0	0	6.00
7.00	SKILLED NURSING FACILITY	0	159,055	0	0	0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00	RURAL HEALTH CLINIC I	0	0	11,624	0	0	10.00
200.00	Total	0	172,254	-146,173	1,298,611	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-2
Part I
Date/Time Prepared:
2/28/2014 2:15 pm

		1.00	2.00	3.00	4.00						
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1005 BROADWAY	PO Box:		Zip Code: 62301	County: ADAMS						1.00
2.00	City: QUINCY	State: IL									2.00
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
							V	XVIII	XIX		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital	BLESSING HOSPITAL	140015	99914	1	07/01/1966	N	P	O	3.00	
4.00	Subprovider - IPF	BLESSING PSYCHIATRIC AT 14TH ST	14S015	99914	4	10/01/1993	N	P	O	4.00	
5.00	Subprovider - IRF	BLESSING REHAB UNIT	14T015	99914	5	10/01/1985	N	P	O	5.00	
6.00	Subprovider - (Other)									6.00	
7.00	Swing Beds - SNF									7.00	
8.00	Swing Beds - NF									8.00	
9.00	Hospital-Based SNF	BLESSING SKILLED CARE UNIT	14S643	99914		06/20/1989	N	P	N	9.00	
10.00	Hospital-Based NF									10.00	
11.00	Hospital-Based OLTC									11.00	
12.00	Hospital-Based HHA	BLESSING HOME CARE	147031	99914		12/01/1984	N	P	N	12.00	
13.00	Separately Certified ASC									13.00	
14.00	Hospital-Based Hospice	HOSPICE OF ADAMS COUNTY	141501	99914		06/01/1984				14.00	
15.00	Hospital-Based Health Clinic - RHC	GOLDEN CLINIC	143422	99914		09/08/1996	N	O	N	15.00	
16.00	Hospital-Based Health Clinic - FQHC									16.00	
17.00	Hospital-Based (CMHC) I									17.00	
18.00	Renal Dialysis									18.00	
19.00	Other									19.00	
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2012	09/30/2013				20.00
21.00	Type of Control (see instructions)					2					21.00
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N				22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3		N			23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	4,655	0	591	0	264	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.	281	0	72	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.					1				35.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part I Date/Time Prepared: 2/28/2014 2:15 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	10/01/2012	09/30/2013	36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00		
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00		
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		39.00		
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	Y			60.00	
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00 61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted FTE Count 3.00	IME 4.00	Unweighted Direct GME FTE Count 5.00
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.				0.00	0.00 61.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140015

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From 10/01/2012
To 09/30/2013

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Part I
Date/Time Prepared:
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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count				
		1.00	2.00	3.00	4.00				
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20			
		1.00							
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	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00	4.00	5.00			
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
				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 associated with primary care FTEs for each primary care program in which you trained residents. 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	4.00	5.00			
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140015

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From 10/01/2012
To 09/30/2013

Worksheet S-2
Part I
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y		70.00	
71.00	If line 70 yes: column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			N	N	0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y		75.00	
76.00	If line 75 yes: column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			N	N	0	76.00
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00	
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00	
					V	XIX	
					1.00	2.00	
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00	

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		V	XIX			
		1.00	2.00			
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	765,134	1,945,615	0		118.01
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		Y			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		Y		N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		14H132	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-2
Part I
Date/Time Prepared:
2/28/2014 2:15 pm

		1.00	2.00				3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: BLESSING CORPORATE SERVICES	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 131				141.00	
142.00	Street: BROADWAY AT 11TH STREET	PO Box:						142.00	
143.00	City: QUINCY	State: IL		Zip Code: 62301				143.00	
							1.00		
144.00	Are provider based physicians' costs included in worksheet A?						Y	144.00	
145.00	If costs for renal services are claimed on worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.						Y	145.00	
							1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N	146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00	
		Part A	Part B	Title V	Title XIX				
		1.00	2.00	3.00	4.00				
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N			155.00	
156.00	Subprovider - IPF	N	N	N	N			156.00	
157.00	Subprovider - IRF	N	N	N	N			157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF	N	N	N	N			159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N			160.00	
161.00	CMHC		N	N	N			161.00	
							1.00		
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5							0.00	166.00
							1.00		
Health Information Technology (HIT) Incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0.00	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)							0.50	169.00
							Beginning	Ending	
							1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						10/01/2012	09/30/2013	170.00

		Y/N	Date	
		1.00	2.00	
<p>General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation</p>				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions)	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	Y	Y	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N		11.00
			Y/N	
			1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
Description		Y/N	Date	Y/N
0		1.00	2.00	3.00
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		N
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	12/31/2013	Y
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		N
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		N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N

	Description	Part A		Part B	
		Y/N	Date	Y/N	
	0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			Y	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			Y	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONNIE	ZIEGLER		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLESSING CORPORATE SERVICES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-223-8400, x4159	CZIEGLER@BLESSINGHOSPITAL.COM		43.00

		Part B	
		Date	
		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)		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)	12/31/2013	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.		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.		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:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		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, REVENUE INTEGRITY	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-2
Part IX
Date/Time Prepared:
2/28/2014 2:15 pm

		Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on w/s B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on w/s C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on w/s D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on w/s C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "o") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
2/28/2014 2:15 pm

Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	I/P Days / O/P	
	Line Number		Available		Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	164	59,860	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		164	59,860	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	25	9,125	0.00	0	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	13.00
14.00 Total (see instructions)		189	68,985	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	60	21,900		0	16.00
17.00 SUBPROVIDER - IRF	41.00	18	6,570		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	20	7,300		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		287				27.00
28.00 Observation Bed Days					0	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)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	20,251	3,766	32,402			1.00
2.00 HMO and other (see instructions)	753	159				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			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)	20,251	3,766	32,402			7.00
8.00 INTENSIVE CARE UNIT	2,625	290	3,951			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		1,295	2,410			13.00
14.00 Total (see instructions)	22,876	5,351	38,763	17.01	1,691.96	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	2,378	4,499	12,068	0.66	77.61	16.00
17.00 SUBPROVIDER - IRF	3,596	353	4,912	0.42	26.40	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	4,752	0	5,652	0.00	30.71	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	44,935	0	58,294	0.00	52.98	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	29.77	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	2,563	0	7,383	0.00	8.03	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				18.09	1,917.46	27.00
28.00 Observation Bed Days		1,274	8,028			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			821			30.00
31.00 Employee discount days - IRF			126			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA	Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	Worksheet S-3 Part I Date/Time Prepared: 2/28/2014 2:15 pm
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Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	5,123	1,399	9,708	1.00	
2.00 HMO and other (see instructions)			178			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	0	5,123	1,399	9,708	14.00	
15.00 CAH visits						15.00	
16.00 SUBPROVIDER - IPF	0.00	0	324	716	2,039	16.00	
17.00 SUBPROVIDER - IRF	0.00	0	261	30	359	17.00	
18.00 SUBPROVIDER						18.00	
19.00 SKILLED NURSING FACILITY	0.00					19.00	
20.00 NURSING FACILITY						20.00	
21.00 OTHER LONG TERM CARE						21.00	
22.00 HOME HEALTH AGENCY	0.00					22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00	
24.00 HOSPICE	0.00					24.00	
24.10 HOSPICE (non-distinct part)						24.10	
25.00 CMHC - CMHC						25.00	
26.00 RURAL HEALTH CLINIC	0.00					26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25	
27.00 Total (sum of lines 14-26)	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	
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01	
33.00 LTCH non-covered days						33.00	

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-3
Part II
Date/Time Prepared:
2/28/2014 2:15 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 + col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 + col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	104,884,608	0	104,884,608	4,125,296.76	25.42
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		553,236	0	553,236	3,542.00	156.19
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		6,199,515	0	6,199,515	22,975.31	269.83
6.00	Non-physician-Part B		693,223	0	693,223	23,266.51	29.79
7.00	Interns & residents (in an approved program)	21.00	1,073,548	0	1,073,548	40,270.40	26.66
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	1,430,369	-15,900	1,414,469	65,741.51	21.52
10.00	Excluded area salaries (see instructions)		17,878,279	669,090	18,547,369	611,142.11	30.35
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		295,885	0	295,885	3,873.44	76.39
12.00	Contract management and administrative services		428,049	0	428,049	1,893.60	226.05
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office salaries & wage-related costs		5,074,422	0	5,074,422	59,853.85	84.78
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		34,393,236	0	34,393,236		17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0		18.00
19.00	Excluded areas		3,679,248	0	3,679,248		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		110,589	0	110,589		22.00
22.01	Physician Part A - Teaching		0	0	0		22.01
23.00	Physician Part B		1,147,706	0	1,147,706		23.00
24.00	Wage-related costs (RHC/FQHC)		242,234	0	242,234		24.00
25.00	Interns & residents (in an approved program)		398,369	0	398,369		25.00
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	2,462,070	0	2,462,070	158,398.41	15.54
27.00	Administrative & General	5.00	13,858,196	0	13,858,196	549,459.78	25.22
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00
29.00	Maintenance & Repairs	6.00	2,419,069	0	2,419,069	118,047.85	20.49
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00
31.00	Laundry & Linen Service	8.00	61,611	0	61,611	5,460.12	11.28
32.00	Housekeeping	9.00	2,082,453	0	2,082,453	164,773.99	12.64
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	2,215,308	-1,589,705	625,603	51,220.79	12.21
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	1,589,705	1,589,705	130,155.94	12.21
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	5,381,234	-14,565	5,366,669	213,766.28	25.11
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00
41.00	Medical Records & Medical Records Library	16.00	1,981,421	0	1,981,421	113,570.02	17.45

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-3
Part II
Date/Time Prepared:
2/28/2014 2:15 pm

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

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-3
Part III
Date/Time Prepared:
2/28/2014 2:15 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from worksheet A-6)	Adjusted Salaries (col. 2 + col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 + col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	96,918,322	0	96,918,322	4,038,784.54	24.00	1.00
2.00	Excluded area salaries (see instructions)	19,308,648	653,190	19,961,838	676,883.62	29.49	2.00
3.00	Subtotal salaries (line 1 minus line 2)	77,609,674	-653,190	76,956,484	3,361,900.92	22.89	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,798,356	0	5,798,356	65,620.89	88.36	4.00
5.00	Subtotal wage-related costs (see inst.)	34,503,825	0	34,503,825	0.00	44.84	5.00
6.00	Total (sum of lines 3 thru 5)	117,911,855	-653,190	117,258,665	3,427,521.81	34.21	6.00
7.00	Total overhead cost (see instructions)	30,461,362	-14,565	30,446,797	1,504,853.18	20.23	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet 5-3
Part IV
Date/Time Prepared:
2/28/2014 2:15 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	3,214,069	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	6,632,501	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)	21,049,147	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	101,546	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	215,022	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	570,949	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	6,845,767	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	269,162	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	1,073,219	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	39,971,382	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: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-3
Part V
Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	295,885	39,971,382	1.00
2.00	Hospital	295,885	37,600,940	2.00
3.00	Subprovider - IPF	0	686,436	3.00
4.00	Subprovider - IRF	0	255,142	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	260,707	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	707,755	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	295,896	13.00
14.00	Hospital-Based Health Clinic RHC	0	164,506	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA	Provider CCN: 140015 Component CCN: 147031	Period: From 10/01/2012 To 09/30/2013	Worksheet S-4 Date/Time Prepared: 2/28/2014 2:15 pm
		Home Health Agency I	PPS

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

HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	10,733	0	2,272	13,005	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	1,290.00	0.00	688.00	1,978.00	2.00

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

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel			9.85	0.00	9.85	5.00
6.00	Direct Nursing Service			19.95	0.00	19.95	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			9.15	0.00	9.15	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			3.57	0.00	3.57	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.66	0.00	0.66	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			2.54	0.00	2.54	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			6.25	0.00	6.25	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00

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

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

PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	19,637	3,898	393	252	24,180	21.00
22.00	Skilled Nursing Visit Charges	2,854,448	571,536	54,684	35,868	3,516,536	22.00
23.00	Physical Therapy Visits	9,068	474	68	118	9,728	23.00
24.00	Physical Therapy Visit Charges	1,326,234	69,237	9,702	17,052	1,422,225	24.00
25.00	Occupational Therapy Visits	3,628	257	15	32	3,932	25.00
26.00	Occupational Therapy Visit Charges	532,287	37,632	2,205	4,704	576,828	26.00
27.00	Speech Pathology Visits	546	39	1	0	586	27.00
28.00	Speech Pathology Visit Charges	78,792	5,733	147	0	84,672	28.00
29.00	Medical Social Service Visits	74	3	1	0	78	29.00
30.00	Medical Social Service Visit Charges	10,731	441	147	0	11,319	30.00
31.00	Home Health Aide Visits	4,112	2,269	4	46	6,431	31.00
32.00	Home Health Aide Visit Charges	336,036	185,730	328	3,690	525,784	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	37,065	6,940	482	448	44,935	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	5,138,528	870,309	67,213	61,314	6,137,364	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,899		176	37	2,112	36.00
37.00	Total Number of Outlier Episodes		120		1	121	37.00
38.00	Total Non-Routine Medical Supply Charges	46,349	29,603	590	300	76,842	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	Worksheet S-7	
				Date/Time Prepared: 2/28/2014 2:15 pm	
		1.00	2.00		
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N			2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	14	0	14 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	204	0	204 7.00
8.00		RHL	168	0	168 8.00
9.00		RMX	74	0	74 9.00
10.00		RML	64	0	64 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	19	0	19 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	128	0	128 15.00
16.00		RVB	27	0	27 16.00
17.00		RVA	82	0	82 17.00
18.00		RHC	1,024	0	1,024 18.00
19.00		RHB	823	0	823 19.00
20.00		RHA	899	0	899 20.00
21.00		RMC	103	0	103 21.00
22.00		RMB	170	0	170 22.00
23.00		RMA	145	0	145 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	246	0	246 28.00
29.00		HE2	13	0	13 29.00
30.00		HE1	23	0	23 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	24	0	24 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	49	0	49 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	139	0	139 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	28	0	28 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	37	0	37 42.00
43.00		LB2	10	0	10 43.00
44.00		LB1	14	0	14 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	14	0	14 47.00
48.00		CD1	13	0	13 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	32	0	32 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	54	0	54 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	108	0	108 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-7

Date/Time Prepared:
2/28/2014 2:15 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	4	0	4	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		4,752	0	4,752	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)
		1.00	2.00

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

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?
		1.00	2.00	3.00

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

202.00	Staffing	1,430,369	30.87	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	4,632,873			207.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140015 Component CCN: 143422	Period: From 10/01/2012 To 09/30/2013	Worksheet S-8 Date/Time Prepared: 2/28/2014 2:15 pm Cost	
			Rural Health Clinic (RHC) I	1.00	
1.00	Clinic Address and Identification		102 PRAIRIE MILLS ROAD		
	Street		City	State	Zip Code
			1.00	2.00	3.00
2.00	City, State, Zip Code, County		GOLDEN	IL	62339
				1.00	2.00
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			Grant Award	Date
				1.00	2.00
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0	5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0	6.00
7.00	Appalachian Regional Commission			0	7.00
8.00	Look-Alikes			0	8.00
9.00	OTHER (SPECIFY)			0	9.00
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N		0
Facility hours of operations (1)					
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		Wednesday	
		from		from	
		1.00		2.00	
11.00	Clinic		09:00	17:00	09:00
12.00	Have you received an approval for an exception to the productivity standard?			N	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0
Provider name, CCN number					
		Provider name		CCN number	
		1.00		2.00	
14.00	Provider name, CCN number				
Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		N	0	0
City, State, Zip Code, County					
		County		ADAMS	
		4.00			
2.00	City, State, Zip Code, County		ADAMS		
Facility hours of operations (1)					
		Tuesday		Wednesday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		Thursday		Friday	
		from		to	
		6.00		10.00	
11.00	Clinic		17:00	09:00	17:00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140015 Component CCN: 143422	Period: From 10/01/2012 To 09/30/2013	Worksheet S-8 Date/Time Prepared: 2/28/2014 2:15 pm
			Rural Health Clinic (RHC) I	Cost
		Friday		Saturday
		from	to	from
		11.00	12.00	13.00
				14.00
11.00	Facility hours of operations (1) clinic	09:00	17:00	
				11.00

Provider CCN: 140015
Component CCN: 141501

Period:
From 10/01/2012
To 09/30/2013

Worksheet 5-9
Parts I & II
Date/Time Prepared:
2/28/2014 2:15 pm

		Hospice I						
		Unduplicated Days						
		Title XVII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
PART I - ENROLLMENT DAYS								
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	17,144	176	0	71	845	18,165	2.00
3.00	Inpatient Respite Care	22	5	0	0	0	27	3.00
4.00	General Inpatient Care	179	17	0	0	67	263	4.00
5.00	Total Hospice Days	17,345	198	0	71	912	18,455	5.00
PART II - CENSUS DATA								
6.00	Number of Patients Receiving Hospice Care	477	44	0	6	27	548	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	36.36	4.50	0.00	11.83	33.78	33.68	8.00
9.00	Unduplicated Census Count	469	44	0	6	27	540	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	Worksheet S-10 Date/Time Prepared: 2/28/2014 2:15 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.271693	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		15,136,611	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		8,083,421	5.00
6.00	Medicaid charges		104,588,900	6.00
7.00	Medicaid cost (line 1 times line 6)		28,416,072	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)		5,196,040	8.00
State children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		5,196,040	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	27,899,278	35,104,604	63,003,882
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	7,580,039	9,537,675	17,117,714
22.00	Partial payment by patients approved for charity care	47,842	140,227	188,069
23.00	Cost of charity care (line 21 minus line 22)	7,532,197	9,397,448	16,929,645
				1.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		23,305,071	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		1,057,270	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)		22,247,801	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		6,044,572	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		22,974,217	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		28,170,257	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140015

Period: From 10/01/2012 To 09/30/2013

Worksheet A

Date/Time Prepared: 2/28/2014 2:15 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	5,056	5,056	22,754	27,810	1.01
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT	215,131	215,131	43,705	258,836	1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT	3,058,868	3,058,868	415,599	3,474,467	1.03
1.04	00104	CAP REL COSTS-14TH STREET	277,665	277,665	1,217,882	1,495,547	1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	0	0	239,641	239,641	1.05
2.00	00200	CAP REL COSTS-MVBLE EQUIP	10,802,743	10,802,743	440,616	11,243,359	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,462,070	41,799,323	44,261,393	44,261,393	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,858,196	51,965,934	65,824,130	252,886	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,419,069	3,861,773	6,280,842	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	61,611	997,236	1,058,847	0	8.00
9.00	00900	HOUSEKEEPING	2,082,453	397,900	2,480,353	0	9.00
10.00	01000	DIETARY	2,215,308	3,146,421	5,361,729	-3,847,577	10.00
11.00	01100	CAFETERIA	0	0	0	3,847,577	11.00
13.00	01300	NURSING ADMINISTRATION	5,381,234	859,578	6,240,812	-14,608	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,981,421	989,053	2,970,474	0	16.00
20.00	02000	NURSING SCHOOL	2,869,255	1,207,604	4,076,859	711,548	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,073,548	0	1,073,548	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	2,044,783	2,044,783	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	235,081	6,530	241,611	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	84,892	2,962	87,854	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,470,122	1,400,745	14,870,867	-588,985	30.00
31.00	03100	INTENSIVE CARE UNIT	3,255,235	1,461,331	4,716,566	-178,590	31.00
40.00	04000	SUBPROVIDER - IPF	3,764,337	101,436	3,865,773	-41,116	40.00
41.00	04100	SUBPROVIDER - IRF	1,401,172	259,979	1,661,151	-24,590	41.00
43.00	04300	NURSERY	430,433	84,735	515,168	-107,103	43.00
44.00	04400	SKILLED NURSING FACILITY	1,430,369	138,986	1,569,355	-36,616	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,880,782	16,643,667	24,524,449	-12,366,336	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,124,478	486,705	1,611,183	-120,153	52.00
53.00	05300	ANESTHESIOLOGY	163,733	376,579	540,312	-134,137	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,782,740	2,400,839	7,183,579	-363,901	54.00
60.00	06000	LABORATORY	2,984,357	2,742,714	5,727,071	-68,833	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	117,613	1,102,494	1,220,107	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,909,998	352,990	2,262,988	-103,246	65.00
66.00	06600	PHYSICAL THERAPY	1,362,333	138,180	1,500,513	-927	66.00
67.00	06700	OCCUPATIONAL THERAPY	534,182	4,168	538,350	-702	67.00
68.00	06800	SPEECH PATHOLOGY	244,531	7,029	251,560	-4,356	68.00
69.00	06900	ELECTROCARDIOLOGY	1,479,329	3,540,906	5,020,235	-2,798,045	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	249,934	71,040	320,974	-18	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	673,002	558,071	1,231,073	5,866,301	7,097,374
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,249,959	10,249,959
73.00	07300	DRUGS CHARGED TO PATIENTS	3,189,948	11,654,503	14,844,451	-210	14,844,241
74.00	07400	RENAL DIALYSIS	0	574,928	574,928	-326	574,602
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	419,334	464,814	884,148	-1,171	882,977
90.00	09000	CLINIC	127,593	66,912	194,505	-177	194,328
91.00	09100	EMERGENCY	9,641,373	806,255	10,447,628	-20,379	10,427,249
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,839,939	1,430,071	5,270,010	-1,683	5,268,327
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	2,498,966	2,498,966	-2,498,966	0
116.00	11600	HOSPICE	1,605,389	557,715	2,163,104	-259	2,162,845
118.00	11800	SUBTOTALS (SUM OF LINES 1-117)	100,806,394	171,565,318	272,371,712	-14,542	272,357,170
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,451,052	216,261	3,667,313	0	3,667,313
192.01	19201	FASTCARE	459,574	111,184	570,758	0	570,758
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.02	19302	DENMAN SERVICES	0	0	0	0	0
193.03	19303	MEALS ON WHEELS	0	0	0	0	0
193.04	19304	UNUSED SPACE	0	0	0	0	0
193.05	19305	HEALTH EDUCATION	0	0	0	14,542	14,542
193.06	19306	RENTED SPACE	0	0	0	0	0
193.07	19307	AUGUSTA PHARMACY	167,588	649,445	817,033	0	817,033
200.00	20000	TOTAL (SUM OF LINES 118-199)	104,884,608	172,542,208	277,426,816	0	277,426,816

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

worksheet A

Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	0	27,810	1.01
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT	0	258,836	1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT	-432,372	3,042,095	1.03
1.04	00104	CAP REL COSTS-14TH STREET	-1,218,654	276,893	1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	-179,634	60,007	1.05
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-520,406	10,722,953	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-22,884,985	21,376,408	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-30,134,205	35,942,811	5.00
6.00	00600	MAINTENANCE & REPAIRS	-583,635	5,697,207	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	-38,386	1,020,461	8.00
9.00	00900	HOUSEKEEPING	-282,858	2,197,495	9.00
10.00	01000	DIETARY	-723,138	791,014	10.00
11.00	01100	CAFETERIA	-1,331,024	2,516,553	11.00
13.00	01300	NURSING ADMINISTRATION	-143,538	6,082,666	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-169,446	2,801,028	16.00
20.00	02000	NURSING SCHOOL	-3,149,776	1,638,631	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,073,548	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	2,044,783	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	-80,658	160,953	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	-23,211	64,643	23.02
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-7,887	14,273,995	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,280,895	3,257,081	31.00
40.00	04000	SUBPROVIDER - IPF	0	3,824,657	40.00
41.00	04100	SUBPROVIDER - IRF	-14,115	1,622,446	41.00
43.00	04300	NURSERY	0	408,065	43.00
44.00	04400	SKILLED NURSING FACILITY	-755	1,531,984	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,106,794	11,051,319	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,491,030	52.00
53.00	05300	ANESTHESIOLOGY	0	406,175	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,819,678	54.00
60.00	06000	LABORATORY	-64,364	5,593,874	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,220,107	62.00
65.00	06500	RESPIRATORY THERAPY	-21,145	2,138,597	65.00
66.00	06600	PHYSICAL THERAPY	-18,004	1,481,582	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	537,648	67.00
68.00	06800	SPEECH PATHOLOGY	0	247,204	68.00
69.00	06900	ELECTROCARDIOLOGY	-37,492	2,184,698	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-45,097	275,859	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,097,374	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,249,959	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,313,037	12,531,204	73.00
74.00	07400	RENAL DIALYSIS	0	574,602	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-40,627	842,350	88.00
90.00	09000	CLINIC	-25,121	169,207	90.00
91.00	09100	EMERGENCY	-5,801,555	4,625,694	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	5,268,327	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	-27,952	2,134,893	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-72,700,766	199,656,404	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,667,313	192.00
192.01	19201	FASTCARE	0	570,758	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
193.02	19302	DENMAN SERVICES	0	0	193.02
193.03	19303	MEALS ON WHEELS	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	193.04
193.05	19305	HEALTH EDUCATION	0	14,542	193.05
193.06	19306	RENTED SPACE	0	0	193.06
193.07	19307	AUGUSTA PHARMACY	0	817,033	193.07
200.00		TOTAL (SUM OF LINES 118-199)	-72,700,766	204,726,050	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet Non-CMS W

Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
1.01	CAP REL COSTS-BUTLER BUILDING	00101		1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	00102		1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	00103		1.03
1.04	CAP REL COSTS-14TH STREET	00104		1.04
1.05	CAP REL COSTS-MOB PHASE I	00105		1.05
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
20.00	NURSING SCHOOL	02000		20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	02100		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	02200		22.00
23.00	PARAMED ED PRGM-(SPECIFY)	02300		23.00
23.01	PARAMED ED PRGM-RADIOLOGY	02301		23.01
23.02	PARAMED ED PRGM-LABORATORY	02302		23.02
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
41.00	SUBPROVIDER - IRF	04100		41.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	06200		62.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	08800		88.00
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY	10100		101.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
116.00	HOSPICE	11600		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	FASTCARE	19201		192.01
193.00	NONPAID WORKERS	19300		193.00
193.02	DENMAN SERVICES	19302		193.02
193.03	MEALS ON WHEELS	19303		193.03
193.04	UNUSED SPACE	19304		193.04
193.05	HEALTH EDUCATION	19305		193.05
193.06	RENTED SPACE	19306		193.06
193.07	AUGUSTA PHARMACY	19307		193.07
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-6

Date/Time Prepared:
2/28/2014 2:15 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	1,589,705	2,257,872	1.00
	TOTALS		1,589,705	2,257,872	
B - RECLASS C-SECTION COSTS					
1.00	OPERATING ROOM	50.00	10,592	0	1.00
	TOTALS		10,592	0	
D - RECLASS CAPITAL RELATED INSURANCE					
1.00	CAP REL COSTS-BUTLER BUILDING	1.01	0	22,754	1.00
2.00	CAP REL COSTS-OLD BUILDING & FIXT	1.02	0	43,705	2.00
3.00	CAP REL COSTS-NEW BUILDING & FIXT	1.03	0	63,130	3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,331	4.00
	TOTALS		0	136,920	
F - RECLASS HEALTH EDUCATION					
1.00	HEALTH EDUCATION	193.05	14,499	43	1.00
	TOTALS		14,499	43	
G - RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-NEW BUILDING & FIXT	1.03	0	352,469	1.00
2.00	CAP REL COSTS-14TH STREET	1.04	0	1,217,882	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	433,285	3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	495,330	4.00
	TOTALS		0	2,498,966	
H - RECLASS ER PHYSICIAN MALPRACTICE INS					
1.00	EMERGENCY	91.00	0	105,524	1.00
	TOTALS		0	105,524	
I - RECLASS CHARGEABLE MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,866,301	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,249,959	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	TOTALS		0	16,116,260	
J - RECLASS PRECEPTOR PAY					
1.00	NURSING SCHOOL	20.00	711,548	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		711,548	0	
K - RECLASS RENT EXPENSE					
1.00	CAP REL COSTS-MOB PHASE I	1.05	0	239,641	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	239,641	
500.00	Grand Total: Increases		2,326,344	21,355,226	500.00

RECLASSIFICATIONS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-6

Date/Time Prepared:
2/28/2014 2:15 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	1,589,705	2,257,872	0	1.00
	TOTALS		1,589,705	2,257,872		
B - RECLASS C-SECTION COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	10,592	0	0	1.00
	TOTALS		10,592	0		
D - RECLASS CAPITAL RELATED INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	136,920	12	1.00
2.00		0.00	0	0	12	2.00
3.00		0.00	0	0	12	3.00
4.00		0.00	0	0	12	4.00
	TOTALS		0	136,920		
F - RECLASS HEALTH EDUCATION						
1.00	NURSING ADMINISTRATION	13.00	14,499	43	0	1.00
	TOTALS		14,499	43		
G - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	2,498,966	11	1.00
2.00		0.00	0	0	11	2.00
3.00		0.00	0	0	11	3.00
4.00		0.00	0	0	0	4.00
	TOTALS		0	2,498,966		
H - RECLASS ER PHYSICIAN MALPRACTICE INS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	105,524	0	1.00
	TOTALS		0	105,524		
I - RECLASS CHARGEABLE MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	194,407	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	124,834	0	2.00
3.00	SUBPROVIDER - IPF	40.00	0	1,051	0	3.00
4.00	SUBPROVIDER - IRF	41.00	0	7,698	0	4.00
5.00	NURSERY	43.00	0	44,652	0	5.00
6.00	SKILLED NURSING FACILITY	44.00	0	20,716	0	6.00
7.00	OPERATING ROOM	50.00	0	12,166,387	0	7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	80,737	0	8.00
9.00	ANESTHESIOLOGY	53.00	0	134,137	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	284,394	0	10.00
11.00	LABORATORY	60.00	0	68,833	0	11.00
12.00	RESPIRATORY THERAPY	65.00	0	103,246	0	12.00
13.00	PHYSICAL THERAPY	66.00	0	927	0	13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	702	0	14.00
15.00	SPEECH PATHOLOGY	68.00	0	4,356	0	15.00
16.00	ELECTROCARDIOLOGY	69.00	0	2,789,834	0	16.00
17.00	ELECTROENCEPHALOGRAPHY	70.00	0	18	0	17.00
18.00	DRUGS CHARGED TO PATIENTS	73.00	0	210	0	18.00
19.00	RENAL DIALYSIS	74.00	0	326	0	19.00
20.00	RURAL HEALTH CLINIC	88.00	0	1,171	0	20.00
21.00	CLINIC	90.00	0	177	0	21.00
22.00	EMERGENCY	91.00	0	85,505	0	22.00
23.00	HOME HEALTH AGENCY	101.00	0	1,683	0	23.00
24.00	HOSPICE	116.00	0	259	0	24.00
	TOTALS		0	16,116,260		
J - RECLASS PRECEPTOR PAY						
1.00	NURSING ADMINISTRATION	13.00	66	0	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	394,578	0	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	53,756	0	0	3.00
4.00	SUBPROVIDER - IPF	40.00	40,065	0	0	4.00
5.00	SUBPROVIDER - IRF	41.00	16,892	0	0	5.00
6.00	NURSERY	43.00	62,451	0	0	6.00
7.00	SKILLED NURSING FACILITY	44.00	15,900	0	0	7.00
8.00	OPERATING ROOM	50.00	50,407	0	0	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	28,824	0	0	9.00
10.00	ELECTROCARDIOLOGY	69.00	8,211	0	0	10.00
11.00	EMERGENCY	91.00	40,398	0	0	11.00
	TOTALS		711,548	0		
K - RECLASS RENT EXPENSE						
1.00	OPERATING ROOM	50.00	0	160,134	10	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	79,507	10	2.00
	TOTALS		0	239,641		
500.00	Grand Total: Decreases		2,326,344	21,355,226		500.00

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2,00	3,00	4,00	6,00	7,00	8,00	
A - RECLASS CAFETERIA COSTS						
1.00	CAFETERIA	11.00	1,589,705	DIETARY	10.00	1,589,705
	TOTALS		1,589,705	TOTALS		1,589,705
B - RECLASS C-SECTION COSTS						
1.00	OPERATING ROOM	50.00	10,592	DELIVERY ROOM & LABOR ROOM	52.00	10,592
	TOTALS		10,592	TOTALS		10,592
D - RECLASS CAPITAL RELATED INSURANCE						
1.00	CAP REL COSTS-BUTLER BUILDING	1.01	0	ADMINISTRATIVE & GENERAL	5.00	0
2.00	CAP REL COSTS-OLD BUILDING & FIXT	1.02	0		0.00	0
3.00	CAP REL COSTS-NEW BUILDING & FIXT	1.03	0		0.00	0
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0		0.00	0
	TOTALS		0	TOTALS		0
F - RECLASS HEALTH EDUCATION						
1.00	HEALTH EDUCATION	193.05	14,499	NURSING ADMINISTRATION	13.00	14,499
	TOTALS		14,499	TOTALS		14,499
G - RECLASS INTEREST EXPENSE						
1.00	CAP REL COSTS-NEW BUILDING & FIXT	1.03	0	INTEREST EXPENSE	113.00	0
2.00	CAP REL COSTS-14TH STREET	1.04	0		0.00	0
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0		0.00	0
4.00	ADMINISTRATIVE & GENERAL	5.00	0		0.00	0
	TOTALS		0	TOTALS		0
H - RECLASS ER PHYSICIAN MALPRACTICE INS						
1.00	EMERGENCY	91.00	0	ADMINISTRATIVE & GENERAL	5.00	0
	TOTALS		0	TOTALS		0
I - RECLASS CHARGEABLE MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	ADULTS & PEDIATRICS	30.00	0
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	INTENSIVE CARE UNIT	31.00	0
3.00		0.00	0	SUBPROVIDER - IPF	40.00	0
4.00		0.00	0	SUBPROVIDER - IRF	41.00	0
5.00		0.00	0	NURSERY	43.00	0
6.00		0.00	0	SKILLED NURSING FACILITY	44.00	0
7.00		0.00	0	OPERATING ROOM	50.00	0
8.00		0.00	0	DELIVERY ROOM & LABOR ROOM	52.00	0
9.00		0.00	0	ANESTHESIOLOGY	53.00	0
10.00		0.00	0	RADIOLOGY-DIAGNOSTIC	54.00	0
11.00		0.00	0	LABORATORY	60.00	0
12.00		0.00	0	RESPIRATORY THERAPY	65.00	0
13.00		0.00	0	PHYSICAL THERAPY	66.00	0
14.00		0.00	0	OCCUPATIONAL THERAPY	67.00	0
15.00		0.00	0	SPEECH PATHOLOGY	68.00	0
16.00		0.00	0	ELECTROCARDIOLOGY	69.00	0
17.00		0.00	0	ELECTROENCEPHALOGRAPHY	70.00	0
18.00		0.00	0	DRUGS CHARGED TO PATIENTS	73.00	0
19.00		0.00	0	RENAL DIALYSIS	74.00	0
20.00		0.00	0	RURAL HEALTH CLINIC	88.00	0
21.00		0.00	0	CLINIC	90.00	0
22.00		0.00	0	EMERGENCY	91.00	0
23.00		0.00	0	HOME HEALTH AGENCY	101.00	0
24.00		0.00	0	HOSPICE	116.00	0
	TOTALS		0	TOTALS		0
J - RECLASS PRECEPTOR PAY						
1.00	NURSING SCHOOL	20.00	711,548	NURSING ADMINISTRATION	13.00	66
2.00		0.00	0	ADULTS & PEDIATRICS	30.00	394,578
3.00		0.00	0	INTENSIVE CARE UNIT	31.00	53,756
4.00		0.00	0	SUBPROVIDER - IPF	40.00	40,065
5.00		0.00	0	SUBPROVIDER - IRF	41.00	16,892
6.00		0.00	0	NURSERY	43.00	62,451
7.00		0.00	0	SKILLED NURSING FACILITY	44.00	15,900
8.00		0.00	0	OPERATING ROOM	50.00	50,407
9.00		0.00	0	DELIVERY ROOM & LABOR ROOM	52.00	28,824
10.00		0.00	0	ELECTROCARDIOLOGY	69.00	8,211
11.00		0.00	0	EMERGENCY	91.00	40,398
	TOTALS		711,548	TOTALS		711,548
K - RECLASS RENT EXPENSE						
1.00	CAP REL COSTS-MOB PHASE I	1.05	0	OPERATING ROOM	50.00	0
2.00		0.00	0	RADIOLOGY-DIAGNOSTIC	54.00	0
	TOTALS		0	TOTALS		0
500.00	Grand Total: Increases		2,326,344	Grand Total: Decreases		2,326,344

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-7
Part I
Date/Time Prepared:
2/28/2014 2:15 pm

		Beginning Balances	Acquisitions		Total	Disposals and Retirements	
			Purchases	Donation			
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	12,863,856	255,878	0	255,878	0	1.00
2.00	Land Improvements	6,408,794	150,152	0	150,152	0	2.00
3.00	Buildings and Fixtures	97,480,903	3,224,299	0	3,224,299	0	3.00
4.00	Building Improvements	3,564,673	0	0	0	0	4.00
5.00	Fixed Equipment	36,382,941	795,953	0	795,953	0	5.00
6.00	Movable Equipment	133,874,621	16,788,793	0	16,788,793	272,934	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	290,575,788	21,215,075	0	21,215,075	272,934	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	290,575,788	21,215,075	0	21,215,075	272,934	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	13,119,734	0				1.00
2.00	Land Improvements	6,558,946	0				2.00
3.00	Buildings and Fixtures	100,705,202	0				3.00
4.00	Building Improvements	3,564,673	0				4.00
5.00	Fixed Equipment	37,178,894	0				5.00
6.00	Movable Equipment	150,390,480	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	311,517,929	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	311,517,929	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-7
Part II
Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	5,056	0	0	0	0	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	215,131	0	0	0	0	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	3,058,868	0	0	0	0	1.03
1.04	CAP REL COSTS-14TH STREET	277,665	0	0	0	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	0	1.05
2.00	CAP REL COSTS-MVBLE EQUIP	10,802,743	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	14,359,463	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	5,056				1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	0	215,131				1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	0	3,058,868				1.03
1.04	CAP REL COSTS-14TH STREET	0	277,665				1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0				1.05
2.00	CAP REL COSTS-MVBLE EQUIP	0	10,802,743				2.00
3.00	Total (sum of lines 1-2)	0	14,359,463				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-7
Part III
Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL	
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance
	1.00	2.00	3.00	4.00	5.00

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	307,247	0	307,247	0.001053	0	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	87,207,425	0	87,207,425	0.298820	0	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	37,914,247	0	37,914,247	0.129915	0	1.03
1.04	CAP REL COSTS-14TH STREET	16,019,849	0	16,019,849	0.054893	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0.000000	0	1.05
2.00	CAP REL COSTS-MVBLE EQUIP	150,390,480	0	150,390,480	0.515319	0	2.00
3.00	Total (sum of lines 1-2)	291,839,248	0	291,839,248	1.000000	0	3.00

Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL	
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease
	6.00	7.00	8.00	9.00	10.00

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	0	0	5,056	0	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	0	0	0	215,131	0	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	0	0	0	2,978,965	0	1.03
1.04	CAP REL COSTS-14TH STREET	0	0	0	276,892	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	60,007	1.05
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	10,721,831	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	14,197,875	60,007	3.00

Cost Center Description	SUMMARY OF CAPITAL				
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)
	11.00	12.00	13.00	14.00	15.00

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	22,754	0	0	27,810	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	0	43,705	0	0	258,836	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	0	63,130	0	0	3,042,095	1.03
1.04	CAP REL COSTS-14TH STREET	1	0	0	0	276,893	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	60,007	1.05
2.00	CAP REL COSTS-MVBLE EQUIP	-6,209	7,331	0	0	10,722,953	2.00
3.00	Total (sum of lines 1-2)	-6,208	136,920	0	0	14,388,594	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
	1.00	2.00	3.00	4.00	5.00		
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01 Investment income - CAP REL COSTS-BUTLER BUILDING (chapter 2)			0	CAP REL COSTS-BUTLER BUILDING	1.01	0	1.01
1.02 Investment income - CAP REL COSTS-OLD BUILDING & FIXT (chapter 2)			0	CAP REL COSTS-OLD BUILDING & FIXT	1.02	0	1.02
1.03 Investment income - CAP REL COSTS-NEW BUILDING & FIXT (chapter 2)			0	CAP REL COSTS-NEW BUILDING & FIXT	1.03	0	1.03
1.04 Investment income - CAP REL COSTS-14TH STREET (chapter 2)			0	CAP REL COSTS-14TH STREET	1.04	0	1.04
1.05 Investment income - CAP REL COSTS-MOB PHASE I (chapter 2)			0	CAP REL COSTS-MOB PHASE I	1.05	0	1.05
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-378,659		ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-195,681		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-36,246		CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-20,603,956				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	905,403				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-1,331,024		CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients	A	-2,251,375		DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00 Sale of medical records and abstracts	B	-33,194		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)	B	-3,126,291		NURSING SCHOOL	20.00	0	19.00
20.00 Vending machines	B	-81,409		DIETARY	10.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost. Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01 Depreciation - CAP REL COSTS-BUTLER BUILDING			0	CAP REL COSTS-BUTLER BUILDING	1.01	0	26.01

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			1.00	2.00	3.00	4.00	5.00
26.02 Depreciation - CAP REL COSTS-OLD BUILDING & FIXT		0	CAP REL COSTS-OLD BUILDING & FIXT	1.02		0	26.02
26.03 Depreciation - CAP REL COSTS-NEW BUILDING & FIXT		0	CAP REL COSTS-NEW BUILDING & FIXT	1.03		0	26.03
26.04 Depreciation - CAP REL COSTS-14TH STREET		0	CAP REL COSTS-14TH STREET	1.04		0	26.04
26.05 Depreciation - CAP REL COSTS-MOB PHASE I		0	CAP REL COSTS-MOB PHASE I	1.05		0	26.05
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant		0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00		0	32.00
33.00 RENTAL INSURANCE EXPENSE	A	-9,157	ADMINISTRATIVE & GENERAL	5.00		0	33.00
33.01 DAMAGED GOODS	B	32,029	ADMINISTRATIVE & GENERAL	5.00		0	33.01
33.02 CHILD CARE CENTER	B	-1,665,381	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.02
33.03 BOOKKEEPING FEES	B	-128,631	ADMINISTRATIVE & GENERAL	5.00		0	33.03
33.04 RADIOLOGY TUITION	B	-80,658	PARAMED ED PRGM-RADIOLOGY	23.01		0	33.04
33.05 PRINT SHOP	B	-55,735	ADMINISTRATIVE & GENERAL	5.00		0	33.05
33.06 HEALTH PROMOTIONS	B	-143,538	NURSING ADMINISTRATION	13.00		0	33.06
33.07 HOUSEKEEPING SERVICES	B	-282,858	HOUSEKEEPING	9.00		0	33.07
33.08 ADVERTISING	A	-375,918	ADMINISTRATIVE & GENERAL	5.00		0	33.08
33.09 RENTAL PROPERTY EXPENSE	A	-154,190	CAP REL COSTS-NEW BUILDING & FIXT	1.03		9	33.09
33.10 RENTAL PROPERTY EXPENSE	A	-5,571	CAP REL COSTS-MVBLE EQUIP	2.00		11	33.10
33.11 REAL ESTATE TAXES ON RENTAL	A	-73,513	MAINTENANCE & REPAIRS	6.00		0	33.11
33.12 RENTAL PROERTY EXPENSE	A	-63,186	MAINTENANCE & REPAIRS	6.00		0	33.12
33.13 DIETARY CONSULT AUTOS	A	-638	CAP REL COSTS-MVBLE EQUIP	2.00		11	33.13
33.14 INTEREST INCOME	A	-352,469	CAP REL COSTS-NEW BUILDING & FIXT	1.03		11	33.14
33.15 INTEREST INCOME	A	-1,217,881	CAP REL COSTS-14TH STREET	1.04		11	33.15
33.16 INTEREST INCOME	A	-433,285	CAP REL COSTS-MVBLE EQUIP	2.00		11	33.16
33.17 INTEREST INCOME	A	-495,330	ADMINISTRATIVE & GENERAL	5.00		0	33.17
33.18 DIETARY OUTSIDE SERVICES-SALARIES	A	-29,306	DIETARY	10.00		0	33.18
33.19 DIETARY OUTSIDE SERVICES-BENEFITS	A	-11,192	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.19
33.20 PHYSICIAN RECRUITMENT	A	-598,778	ADMINISTRATIVE & GENERAL	5.00		0	33.20
33.21 NURSING SCHOOL ADVERTISING	A	-23,485	NURSING SCHOOL	20.00		0	33.21
33.22 LOBBYING EXPENSE	A	-43,300	ADMINISTRATIVE & GENERAL	5.00		0	33.22
33.23 TRANSFER TO PARENT	A	-496,310	ADMINISTRATIVE & GENERAL	5.00		0	33.23
33.24 HOSPICE PROFESSIONAL FEES	A	-27,952	HOSPICE	116.00		0	33.24
33.25 ER PHYSICIAN BENEFITS	A	-722,938	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.25
33.26 ALCOHOL RELATED EXPENSES	A	-3,000	ADMINISTRATIVE & GENERAL	5.00		0	33.26
33.27 BOOK TO MEDICARE DEPRECIATION	A	74,287	CAP REL COSTS-NEW BUILDING & FIXT	1.03		9	33.27
33.28 BOOK TO MEDICARE DEPRECIATION	A	17,152	CAP REL COSTS-MVBLE EQUIP	2.00		9	33.28
33.29 GROUND FEES	B	-62,373	MAINTENANCE & REPAIRS	6.00		0	33.29
33.30 LABORATORY TUITION	B	-23,211	PARAMED ED PRGM-LABORATORY	23.02		0	33.30
33.31 CV SURGEON BENEFITS	A	-127,808	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.31
33.32 SELF-FUNDED HEALTH INSURANCE	A	-16,620,028	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.32
33.33 STUDER GROUP EXPENSE	A	-286,743	ADMINISTRATIVE & GENERAL	5.00		0	33.33
33.34 TRAUMA ON-CALL	A	-1,003,708	ADMINISTRATIVE & GENERAL	5.00		0	33.34
33.35 NON-HOSPITAL DEPRECIATION	A	-61,818	CAP REL COSTS-MVBLE EQUIP	2.00		9	33.35
33.36 MISCELLANEOUS INCOME	B	-64,096	ADMINISTRATIVE & GENERAL	5.00		0	33.36
33.37 MISCELLANEOUS INCOME	B	-3,645	LABORATORY	60.00		0	33.37
33.38 MISCELLANEOUS INCOME	B	-18,004	PHYSICAL THERAPY	66.00		0	33.38
33.39 MISCELLANEOUS INCOME	B	-4,200	OPERATING ROOM	50.00		0	33.39
33.40 MISCELLANEOUS INCOME	B	-11,487	RESPIRATORY THERAPY	65.00		0	33.40
33.41 MISCELLANEOUS INCOME	B	-38,257	ELECTROENCEPHALOGRAPHY	70.00		0	33.41
33.42 MISCELLANEOUS INCOME	B	-18,294	ADMINISTRATIVE & GENERAL	5.00		0	33.42

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.	
			Cost Center				
	1.00	2.00	3.00	4.00	5.00		
33.43 MISCELLANEOUS INCOME	B	-510,766	ADMINISTRATIVE & GENERAL		5.00	0	33.43
33.44 MISCELLANEOUS INCOME	B	-773	CAP REL COSTS-14TH STREET		1.04	9	33.44
33.45 MISCELLANEOUS INCOME	B	-719	LABORATORY		60.00	0	33.45
33.46 MISCELLANEOUS INCOME	B	-8,949	ELECTROCARDIOLOGY		69.00	0	33.46
33.47 MISCELLANEOUS INCOME	B	-118,942	ADMINISTRATIVE & GENERAL		5.00	0	33.47
33.48 MISCELLANEOUS INCOME	B	-20	OPERATING ROOM		50.00	0	33.48
33.49 MISCELLANEOUS INCOME	B	-23,820	CLINIC		90.00	0	33.49
33.50 CATERING REVENUE	B	-398,584	DIETARY		10.00	0	33.50
33.51 FLOOR STOCK REVENUE	B	-213,839	DIETARY		10.00	0	33.51
33.52 SERVICES TO ILLINI	B	-390	ADMINISTRATIVE & GENERAL		5.00	0	33.52
33.53 BPS EXPENSES	A	-12,551,825	ADMINISTRATIVE & GENERAL		5.00	0	33.53
33.54 ECHO OUTREACH SALARIES	A	-16,939	ELECTROCARDIOLOGY		69.00	0	33.54
33.55 ECHO OUTREACH BENEFITS	A	-6,471	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.55
33.56 PHARMACY COVERAGE SALARIES	A	-36,634	DRUGS CHARGED TO PATIENTS		73.00	0	33.56
33.57 PHARMACY COVERAGE BENEFITS	A	-13,990	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.57
33.58 PHARMACY COVERAGE EXPENSES	A	-25,028	DRUGS CHARGED TO PATIENTS		73.00	0	33.58
33.59 INFORMATION SYSTEMS WAGES	A	-3,738,636	ADMINISTRATIVE & GENERAL		5.00	0	33.59
33.60 INFORMATION SYSTEMS BENEFITS	A	-1,637,547	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.60
33.61 MEDICAL RECORDS SALARIES	A	-90,854	MEDICAL RECORDS & LIBRARY		16.00	0	33.61
33.62 MEDICAL RECORDS BENEFITS	A	-34,697	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.62
33.63 MEDICAL RECORDS EXPENSES	A	-45,398	MEDICAL RECORDS & LIBRARY		16.00	0	33.63
33.64 PAIN MANAGEMENT NP SALARIES	A	-53,101	OPERATING ROOM		50.00	0	33.64
33.65 PAIN MANAGEMENT NP BENEFITS	A	-20,279	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.65
33.66 PAIN MANAGEMENT NP EXPENSES	A	-622	OPERATING ROOM		50.00	0	33.66
33.67 NP AND PA IN URGENT CARE SALARIES	A	-220,788	EMERGENCY		91.00	0	33.67
33.68 NP AND PA IN URGENT CARE BENEFITS	A	-84,319	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.68
33.69		0			0.00	0	33.69
33.70		0			0.00	0	33.70
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-72,700,766				50.00	

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

Provider CCN: 140015

Period: From 10/01/2012 To 09/30/2013

Worksheet A-8-1

Date/Time Prepared: 2/28/2014 2:15 pm

Line No.	Cost Center	Expense Items \	Amount of Allowable Cost	Amount included in wks. A, column 5		
1.00	2.00	3.00	4.00	5.00		
A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	6.00	MAINTENANCE & REPAIRS	BIO-MED	490,837	875,400	1.00
2.00	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	935,883	974,269	2.00
3.00	88.00	RURAL HEALTH CLINIC	EAST ADAMS RENT	31,683	72,310	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	10,846,170	6,984,249	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	BCS BENEFITS	-1,861,356	0	4.01
4.02	1.05	CAP REL COSTS-MOB PHASE I	SURGERY RENT	22,412	89,504	4.02
4.03	1.05	CAP REL COSTS-MOB PHASE I	RADIOLOGY RENT	19,909	79,507	4.03
4.04	1.05	CAP REL COSTS-MOB PHASE I	WOUND RENT	17,686	70,630	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	PFS AND PT ACCESS COSTS	0	381,134	4.05
4.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	PF AND PT ACCESS BENEFITS	0	65,816	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	ACCOUNTS PAYABLE COSTS	0	3,620	4.07
4.08	4.00	EMPLOYEE BENEFITS DEPARTMENT	ACCOUNTS PAYABLE COSTS	0	1,382	4.08
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.			10,503,224	9,597,821	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	Name	Percentage of Ownership	Related Organization(s) and/or Home Office
1.00	2.00	3.00	4.00	5.00	
B: INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	G		0.00	DENMAN SERVICES	0.00	6.00
7.00	G		0.00	DENMAN SERVICES	0.00	7.00
8.00	G		0.00	BLESSING FOUND	0.00	8.00
9.00	B		0.00	BLESS CORP SVCS	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify: BROTHER/SISTER					100.00

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

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

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

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

worksheet A-8-1

Date/Time Prepared:
2/28/2014 2:15 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-384,563	0		1.00
2.00	-38,386	0		2.00
3.00	-40,627	0		3.00
4.00	3,861,921	0		4.00
4.01	-1,861,356	0		4.01
4.02	-67,092	10		4.02
4.03	-59,598	10		4.03
4.04	-52,944	10		4.04
4.05	-381,134	0		4.05
4.06	-65,816	0		4.06
4.07	-3,620	0		4.07
4.08	-1,382	0		4.08
5.00	905,403			5.00

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

Related Organization(s) and/or Home Office	Type of Business
	6.00

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	BIO-MED MAINT		6.00
7.00	LAUNDRY		7.00
8.00	FUND RAISING		8.00
9.00	HOME OFFICE		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-8-2

Date/Time Prepared:
2/28/2014 2:15 pm

1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00
Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours		
1.00	5.00 ADMINISTRATIVE & GENERAL	1,556,715	1,432,329	124,386	159,800	884	1.00	
2.00	5.00 ADMINISTRATIVE & GENERAL	180,266	0	180,266	208,000	1,140	2.00	
3.00	5.00 ADMINISTRATIVE & GENERAL	1,900,171	1,900,171	0	0	0	3.00	
4.00	5.00 ADMINISTRATIVE & GENERAL	152,971	152,971	0	0	0	4.00	
5.00	4.00 EMPLOYEE BENEFITS DEPARTMENT	11,781	11,781	0	0	0	5.00	
6.00	30.00 ADULTS & PEDIATRICS	17,490	0	17,490	159,800	125	6.00	
7.00	31.00 INTENSIVE CARE UNIT	1,111,170	1,111,170	0	0	0	7.00	
8.00	31.00 INTENSIVE CARE UNIT	169,725	169,725	0	0	0	8.00	
9.00	41.00 SUBPROVIDER - IRF	36,625	0	36,625	159,800	293	9.00	
10.00	44.00 SKILLED NURSING FACILITY	1,600	0	1,600	159,800	11	10.00	
11.00	60.00 LABORATORY	60,000	60,000	0	0	0	11.00	
12.00	65.00 RESPIRATORY THERAPY	9,900	0	9,900	159,800	66	12.00	
13.00	65.00 RESPIRATORY THERAPY	9,900	0	9,900	159,800	66	13.00	
14.00	70.00 ELECTROENCEPHALOGRAPHY	14,750	0	14,750	159,800	118	14.00	
15.00	69.00 ELECTROCARDIOLOGY	9,100	0	9,100	159,800	70	15.00	
16.00	69.00 ELECTROCARDIOLOGY	19,050	0	19,050	182,900	127	16.00	
17.00	70.00 ELECTROENCEPHALOGRAPHY	3,000	0	3,000	159,800	24	17.00	
18.00	91.00 EMERGENCY	13,161	0	13,161	159,800	96	18.00	
19.00	91.00 EMERGENCY	68,000	0	68,000	159,800	533	19.00	
20.00	91.00 EMERGENCY	5,213,296	5,213,296	0	0	0	20.00	
21.00	91.00 EMERGENCY	312,440	0	312,440	159,800	1,987	21.00	
22.00	91.00 EMERGENCY	174,849	174,849	0	0	0	22.00	
23.00	90.00 CLINIC	3,375	0	3,375	159,800	27	23.00	
24.00	50.00 OPERATING ROOM	94,019	0	94,019	182,900	362	24.00	
25.00	5.00 ADMINISTRATIVE & GENERAL	8,961,294	8,961,294	0	0	0	25.00	
26.00	50.00 OPERATING ROOM	445	445	0	0	0	26.00	
27.00	50.00 OPERATING ROOM	986,219	986,219	0	0	0	27.00	
200.00		21,091,312	20,174,250	917,062		5,929	200.00	

1.00	2.00	8.00	9.00	12.00	13.00	14.00	15.00
Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
1.00	5.00 ADMINISTRATIVE & GENERAL	67,915	3,396	0	0	0	1.00
2.00	5.00 ADMINISTRATIVE & GENERAL	114,000	5,700	0	0	0	2.00
3.00	5.00 ADMINISTRATIVE & GENERAL	0	0	0	0	0	3.00
4.00	5.00 ADMINISTRATIVE & GENERAL	0	0	0	0	0	4.00
5.00	4.00 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	5.00
6.00	30.00 ADULTS & PEDIATRICS	9,603	480	0	0	0	6.00
7.00	31.00 INTENSIVE CARE UNIT	0	0	0	0	0	7.00
8.00	31.00 INTENSIVE CARE UNIT	0	0	0	0	0	8.00
9.00	41.00 SUBPROVIDER - IRF	22,510	1,126	0	0	0	9.00
10.00	44.00 SKILLED NURSING FACILITY	845	42	0	0	0	10.00
11.00	60.00 LABORATORY	0	0	0	0	0	11.00
12.00	65.00 RESPIRATORY THERAPY	5,071	254	0	0	0	12.00
13.00	65.00 RESPIRATORY THERAPY	5,071	254	0	0	0	13.00
14.00	70.00 ELECTROENCEPHALOGRAPHY	9,066	453	0	0	0	14.00
15.00	69.00 ELECTROCARDIOLOGY	5,378	269	0	0	0	15.00
16.00	69.00 ELECTROCARDIOLOGY	11,168	558	0	0	0	16.00
17.00	70.00 ELECTROENCEPHALOGRAPHY	1,844	92	0	0	0	17.00
18.00	91.00 EMERGENCY	7,375	369	0	0	0	18.00
19.00	91.00 EMERGENCY	40,949	2,047	0	0	0	19.00
20.00	91.00 EMERGENCY	0	0	0	0	0	20.00
21.00	91.00 EMERGENCY	152,655	7,633	0	0	0	21.00
22.00	91.00 EMERGENCY	0	0	0	0	0	22.00
23.00	90.00 CLINIC	2,074	104	0	0	0	23.00
24.00	50.00 OPERATING ROOM	31,832	1,592	0	0	0	24.00
25.00	5.00 ADMINISTRATIVE & GENERAL	0	0	0	0	0	25.00
26.00	50.00 OPERATING ROOM	0	0	0	0	0	26.00
27.00	50.00 OPERATING ROOM	0	0	0	0	0	27.00
200.00		487,356	24,369	0	0	0	200.00

1.00	2.00	15.00	16.00	17.00	18.00	19.00
Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
1.00	5.00 ADMINISTRATIVE & GENERAL	0	67,915	56,471	1,488,800	1.00
2.00	5.00 ADMINISTRATIVE & GENERAL	0	114,000	66,266	66,266	2.00
3.00	5.00 ADMINISTRATIVE & GENERAL	0	0	0	1,900,171	3.00
4.00	5.00 ADMINISTRATIVE & GENERAL	0	0	0	152,971	4.00
5.00	4.00 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	11,781	5.00
6.00	30.00 ADULTS & PEDIATRICS	0	9,603	7,887	7,887	6.00
7.00	31.00 INTENSIVE CARE UNIT	0	0	0	1,111,170	7.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

worksheet A-8-2

Date/Time Prepared:
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	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
8.00	31.00	INTENSIVE CARE UNIT	0	0	0	169,725		8.00
9.00	41.00	SUBPROVIDER - IRF	0	22,510	14,115	14,115		9.00
10.00	44.00	SKILLED NURSING FACILITY	0	845	755	755		10.00
11.00	60.00	LABORATORY	0	0	0	60,000		11.00
12.00	65.00	RESPIRATORY THERAPY	0	5,071	4,829	4,829		12.00
13.00	65.00	RESPIRATORY THERAPY	0	5,071	4,829	4,829		13.00
14.00	70.00	ELECTROENCEPHALOGRAPHY	0	9,066	5,684	5,684		14.00
15.00	69.00	ELECTROCARDIOLOGY	0	5,378	3,722	3,722		15.00
16.00	69.00	ELECTROCARDIOLOGY	0	11,168	7,882	7,882		16.00
17.00	70.00	ELECTROENCEPHALOGRAPHY	0	1,844	1,156	1,156		17.00
18.00	91.00	EMERGENCY	0	7,375	5,786	5,786		18.00
19.00	91.00	EMERGENCY	0	40,949	27,051	27,051		19.00
20.00	91.00	EMERGENCY	0	0	0	5,213,296		20.00
21.00	91.00	EMERGENCY	0	152,655	159,785	159,785		21.00
22.00	91.00	EMERGENCY	0	0	0	174,849		22.00
23.00	90.00	CLINIC	0	2,074	1,301	1,301		23.00
24.00	50.00	OPERATING ROOM	0	31,832	62,187	62,187		24.00
25.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	8,961,294		25.00
26.00	50.00	OPERATING ROOM	0	0	0	445		26.00
27.00	50.00	OPERATING ROOM	0	0	0	986,219		27.00
200.00			0	487,356	429,706	20,603,956		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part I
Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS				
			BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT	
			1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	27,810	0	27,810	0	1.01
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT	258,836	0	0	258,836	1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT	3,042,095	0	0	0	3,042,095 1.03
1.04	00104	CAP REL COSTS-14TH STREET	276,893	0	0	0	0 1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	60,007	0	0	0	0 1.05
2.00	00200	CAP REL COSTS-MVBLE EQUIP	10,722,953	0	0	0	0 2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	21,376,408	0	0	11,625	157,071 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	35,942,811	0	0	63,677	559,074 5.00
6.00	00600	MAINTENANCE & REPAIRS	5,697,207	0	5,858	35,703	388,849 6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,020,461	0	0	3,522	0 8.00
9.00	00900	HOUSEKEEPING	2,197,495	0	0	7,615	2,498 9.00
10.00	01000	DIETARY	791,014	0	0	0	77,877 10.00
11.00	01100	CAFETERIA	2,516,553	0	0	0	23,296 11.00
13.00	01300	NURSING ADMINISTRATION	6,082,666	0	0	5,829	0 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,801,028	0	0	984	48,024 16.00
20.00	02000	NURSING SCHOOL	1,638,631	0	21,952	0	144,663 20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,073,548	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,044,783	0	0	0	0 22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	160,953	0	0	0	3,503 23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	64,643	0	0	1,022	0 23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,273,995	0	0	15,600	551,120 30.00
31.00	03100	INTENSIVE CARE UNIT	3,257,081	0	0	20,760	83,844 31.00
40.00	04000	SUBPROVIDER - IPF	3,824,657	0	0	0	0 40.00
41.00	04100	SUBPROVIDER - IRF	1,622,446	0	0	1,725	37,564 41.00
43.00	04300	NURSERY	408,065	0	0	0	18,775 43.00
44.00	04400	SKILLED NURSING FACILITY	1,531,984	0	0	0	52,715 44.00
ANCELLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,051,319	0	0	21,764	172,480 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,491,030	0	0	8,336	0 52.00
53.00	05300	ANESTHESIOLOGY	406,175	0	0	1,243	4,602 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,819,678	0	0	0	228,798 54.00
60.00	06000	LABORATORY	5,593,874	0	0	0	82,588 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,220,107	0	0	762	0 62.00
65.00	06500	RESPIRATORY THERAPY	2,138,597	0	0	7,968	0 65.00
66.00	06600	PHYSICAL THERAPY	1,481,582	0	0	4,269	36,098 66.00
67.00	06700	OCCUPATIONAL THERAPY	537,648	0	0	3,251	0 67.00
68.00	06800	SPEECH PATHOLOGY	247,204	0	0	1,101	0 68.00
69.00	06900	ELECTROCARDIOLOGY	2,184,698	0	0	14,401	37,944 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	275,859	0	0	4,328	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,097,374	0	0	0	24,789 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,249,959	0	0	0	43,313 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,531,204	0	0	638	26,697 73.00
74.00	07400	RENAL DIALYSIS	574,602	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	842,350	0	0	0	0 88.00
90.00	09000	CLINIC	169,207	0	0	0	0 90.00
91.00	09100	EMERGENCY	4,625,694	0	0	15,036	120,763 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	5,268,327	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0 113.00
116.00	11600	HOSPICE	2,134,893	0	0	0	0 116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	199,656,404	0	27,810	251,159	2,926,945 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	5,039	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,667,313	0	0	0	0 192.00
192.01	19201	FASTCARE	570,758	0	0	0	0 192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0 193.00
193.02	19302	DENMAN SERVICES	0	0	0	0	6,788 193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0 193.03
193.04	19304	UNUSED SPACE	0	0	0	1,798	1,514 193.04
193.05	19305	HEALTH EDUCATION	14,542	0	0	0	0 193.05
193.06	19306	RENTED SPACE	0	0	0	840	106,848 193.06
193.07	19307	AUGUSTA PHARMACY	817,033	0	0	0	0 193.07

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS				
		BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT	
		1.00	1.01	1.02	1.03	
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)	204,726,050	27,810	258,836	3,042,095	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part I
Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		14TH STREET	MOB PHASE I	MVBLE EQUIP			
		1.04	1.05	2.00			
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT					1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT					1.03
1.04	00104	CAP REL COSTS-14TH STREET	276,893				1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	0	60,007			1.05
2.00	00200	CAP REL COSTS-MVBLE EQUIP			10,722,953		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	483	0	153,370	21,698,957	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	71,615	0	3,597,461	2,325,187	5.00
6.00	00600	MAINTENANCE & REPAIRS	65,183	0	182,198	574,507	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	403	0	4,005	14,632	8.00
9.00	00900	HOUSEKEEPING	2,817	0	97,761	494,564	9.00
10.00	01000	DIETARY	4,263	0	84,030	141,615	10.00
11.00	01100	CAFETERIA	5,481	0	0	377,541	11.00
13.00	01300	NURSING ADMINISTRATION	3,330	0	847,277	1,274,536	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,213	0	291,098	448,993	16.00
20.00	02000	NURSING SCHOOL	8,100	0	51,989	850,408	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	254,958	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	18	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	55,830	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	20,161	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	229,884	3,105,337	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	87,416	760,322	31.00
40.00	04000	SUBPROVIDER - IPF	25,746	0	16,840	884,481	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	26,250	328,754	41.00
43.00	04300	NURSERY	0	0	10,418	87,392	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	2,669	335,924	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	42,661	1,577,888	1,615,330	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	31,138	257,692	52.00
53.00	05300	ANESTHESIOLOGY	0	0	177,206	38,885	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,346	1,890,357	1,135,858	54.00
60.00	06000	LABORATORY	360	0	282,185	708,758	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	27,932	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	453,607	65.00
66.00	06600	PHYSICAL THERAPY	0	0	8,239	323,542	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,924	126,863	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,817	58,074	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	575,696	345,354	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	21,493	59,357	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,246	0	38,639	58,179	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,167	0	46,825	101,653	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	350	0	267,144	748,883	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	99,588	88.00
90.00	09000	CLINIC	0	0	0	30,302	90.00
91.00	09100	EMERGENCY	8,638	0	84,902	915,397	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	5,274	0	17,223	911,951	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	3,977	0	8,633	374,627	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	221,646	60,007	10,714,993	20,726,974	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,363	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,617	0	351	819,594	192.00
192.01	19201	FASTCARE	0	0	7,085	109,145	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.02	19302	DENMAN SERVICES	2,034	0	287	0	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	17,602	0	0	0	193.04
193.05	19305	HEALTH EDUCATION	0	0	0	3,443	193.05
193.06	19306	RENTED SPACE	10,631	0	0	0	193.06
193.07	19307	AUGUSTA PHARMACY	0	0	237	39,801	193.07
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS				Subtotal
	14TH STREET	MOB PHASE I	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
	1.04	1.05	2.00	4.00	
202.00 TOTAL (sum lines 118-201)	276,893	60,007	10,722,953	21,698,957	204,726,050 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00104						1.04
1.05	00105						1.05
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	42,559,825					5.00
6.00	00600	1,823,870	8,773,375				6.00
8.00	00800	273,737	36,611	1,353,371			8.00
9.00	00900	735,571	116,289	3,246	3,657,856		9.00
10.00	01000	288,375	262,548	7,989	50,857	1,708,568	10.00
11.00	01100	767,096	145,273	0	111,454	0	11.00
13.00	01300	2,155,636	102,851	0	53,336	0	13.00
16.00	01600	942,533	147,889	0	39,489	0	16.00
20.00	02000	712,736	733,872	0	104,760	0	20.00
21.00	02100	348,661	0	0	0	0	21.00
22.00	02200	536,650	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
23.01	02301	57,813	8,766	0	2,160	0	23.01
23.02	02302	22,525	8,766	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,770,151	1,513,225	606,607	924,108	943,423	30.00
31.00	03100	1,104,746	387,977	64,715	265,761	114,036	31.00
40.00	04000	1,247,071	408,500	46,958	239,376	346,388	40.00
41.00	04100	529,285	108,814	39,806	92,896	143,313	41.00
43.00	04300	137,692	46,991	5,017	24,472	0	43.00
44.00	04400	504,760	131,936	30,516	86,663	161,408	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,800,597	759,407	181,199	439,900	0	50.00
52.00	05200	469,305	71,524	22,858	97,039	0	52.00
53.00	05300	164,845	22,188	0	0	0	53.00
54.00	05400	2,648,615	629,968	107,644	181,010	0	54.00
60.00	06000	1,749,928	212,413	2,017	66,015	0	60.00
62.00	06200	327,743	6,541	0	1,062	0	62.00
65.00	06500	682,405	68,364	897	72,886	0	65.00
66.00	06600	486,504	126,976	29	57,551	0	66.00
67.00	06700	176,019	27,896	0	0	0	67.00
68.00	06800	80,885	9,446	0	0	0	68.00
69.00	06900	828,829	218,529	24,158	27,766	0	69.00
70.00	07000	94,753	37,138	8,135	13,281	0	70.00
71.00	07100	1,895,969	145,273	7,243	24,047	0	71.00
72.00	07200	2,742,801	253,849	12,656	42,039	0	72.00
73.00	07300	3,562,682	77,843	0	32,264	0	73.00
74.00	07400	150,802	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	247,208	0	0	637	0	88.00
90.00	09000	52,360	0	0	0	0	90.00
91.00	09100	1,514,426	568,315	175,042	324,905	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	1,627,893	83,671	0	130,437	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	661,923	63,097	1,960	22,949	0	116.00
118.00		40,925,400	7,542,746	1,348,692	3,529,120	1,708,568	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	2,205	96,599	4,626	0	0	190.00
192.00	19200	1,183,336	342,973	53	0	0	192.00
192.01	19201	180,297	0	0	0	0	192.01
193.00	19300	0	0	0	0	0	193.00
193.02	19302	2,391	49,268	0	22,099	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	5,489	298,496	0	0	0	193.04
193.05	19305	4,720	0	0	0	0	193.05
193.06	19306	31,052	443,293	0	106,637	0	193.06
193.07	19307	224,935	0	0	0	0	193.07
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		42,559,825	8,773,375	1,353,371	3,657,856	1,708,568	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

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Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	
	11.00	13.00	16.00	20.00	21.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 CAP REL COSTS-BUTLER BUILDING						1.01
1.02 00102 CAP REL COSTS-OLD BUILDING & FIXT						1.02
1.03 00103 CAP REL COSTS-NEW BUILDING & FIXT						1.03
1.04 00104 CAP REL COSTS-14TH STREET						1.04
1.05 00105 CAP REL COSTS-MOB PHASE I						1.05
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA	3,946,694					11.00
13.00 01300 NURSING ADMINISTRATION	292,096	10,817,557				13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	152,323		4,873,574			16.00
20.00 02000 NURSING SCHOOL	195,743			4,462,854		20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0				1,677,167	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	55,028					22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0					23.00
23.01 02301 PARAMED ED PRGM-RADIOLOGY	11,381					23.01
23.02 02302 PARAMED ED PRGM-LABORATORY	3,564					23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	770,877	3,700,038	2,668,601	3,285,473	1,139,127	30.00
31.00 03100 INTENSIVE CARE UNIT	161,918	777,152	322,573	141,817	48,365	31.00
40.00 04000 SUBPROVIDER - IPF	225,433	1,082,046	405,395	323,195	81,819	40.00
41.00 04100 SUBPROVIDER - IRF	76,447	366,927	979,821	0	52,073	41.00
43.00 04300 NURSERY	15,752	75,628	11,629	63,927	29,745	43.00
44.00 04400 SKILLED NURSING FACILITY	89,823	431,145	456,546	186,990	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	383,524	1,840,808	0	152,494	97,966	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	53,976	259,079	0	186,990	0	52.00
53.00 05300 ANESTHESIOLOGY	12,587	60,433	0	0	3,708	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	240,052	0	0	0	3,708	54.00
60.00 06000 LABORATORY	199,761	0	0	0	18,620	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	6,756	0	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	104,850	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	55,145	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	24,603	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	9,331	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	71,396	0	0	8,213	64,435	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	17,221	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	24,140	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	42,187	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	130,060	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 09000 CLINIC	6,656	0	0	0	0	90.00
91.00 09100 EMERGENCY	209,155	1,003,905	29,009	100,340	137,601	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	156,377	750,558	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPICE	87,284	418,927	0	13,415	0	116.00
118.00 11800 SUBTOTALS (SUM OF LINES 1-117)	3,885,446	10,766,646	4,873,574	4,462,854	1,677,167	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	60,396	0	0	0	0	192.00
192.01 19201 FASTCARE	0	50,911	0	0	0	192.01
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.02 19302 DENMAN SERVICES	0	0	0	0	0	193.02
193.03 19303 MEALS ON WHEELS	0	0	0	0	0	193.03
193.04 19304 UNUSED SPACE	0	0	0	0	0	193.04
193.05 19305 HEALTH EDUCATION	852	0	0	0	0	193.05
193.06 19306 RENTED SPACE	0	0	0	0	0	193.06
193.07 19307 AUGUSTA PHARMACY	0	0	0	0	0	193.07
200.00 20000 Cross Foot Adjustments						200.00
201.00 20100 Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

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Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES	
	11.00	13.00	16.00	20.00	21.00	
202.00 TOTAL (sum lines 118-201)	3,946,694	10,817,557	4,873,574	4,462,854	1,677,167	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2012
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Cost Center Description	INTERNS & RESIDENTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	Subtotal	
	SERVICES-OTHER PRGM COSTS					
	22.00					
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 CAP REL COSTS-BUTLER BUILDING						1.01
1.02 00102 CAP REL COSTS-OLD BUILDING & FIXT						1.02
1.03 00103 CAP REL COSTS-NEW BUILDING & FIXT						1.03
1.04 00104 CAP REL COSTS-14TH STREET						1.04
1.05 00105 CAP REL COSTS-MOB PHASE I						1.05
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
13.00 01300 NURSING ADMINISTRATION						13.00
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00
20.00 02000 NURSING SCHOOL						20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	2,636,479					22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0				23.00
23.01 02301 PARAMED ED PRGM-RADIOLOGY	0	0	300,406			23.01
23.02 02302 PARAMED ED PRGM-LABORATORY	0	0	0	120,681		23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRCS	1,790,686	0	0	0	40,288,252	30.00
31.00 03100 INTENSIVE CARE UNIT	76,029	0	0	0	7,674,512	31.00
40.00 04000 SUBPROVIDER - IPF	128,618	0	0	0	9,286,523	40.00
41.00 04100 SUBPROVIDER - IRF	81,859	0	0	0	4,487,980	41.00
43.00 04300 NURSERY	46,759	0	0	0	982,262	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	4,003,079	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	154,001	0	0	0	22,291,338	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	2,948,967	52.00
53.00 05300 ANESTHESIOLOGY	5,830	0	0	0	897,702	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	5,830	0	300,406	0	14,209,270	54.00
60.00 06000 LABORATORY	29,270	0	0	120,681	9,066,470	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	1,590,903	62.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	3,529,574	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	2,579,935	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	899,204	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	407,858	68.00
69.00 06900 ELECTROCARDIOLOGY	101,291	0	0	0	4,502,710	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	531,565	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	9,320,899	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	13,544,449	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	17,377,765	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	725,404	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	1,189,783	88.00
90.00 09000 CLINIC	0	0	0	0	258,525	90.00
91.00 09100 EMERGENCY	216,306	0	0	0	10,049,434	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	8,951,711	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
116.00 11600 HOSPICE	0	0	0	0	3,791,685	116.00
118.00 11800 SUBTOTALS (SUM OF LINES 1-117)	2,636,479	0	300,406	120,681	195,387,759	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	111,832	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	6,095,633	192.00
192.01 19201 FASTCARE	0	0	0	0	918,196	192.01
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.02 19302 DENMAN SERVICES	0	0	0	0	82,867	193.02
193.03 19303 MEALS ON WHEELS	0	0	0	0	0	193.03
193.04 19304 UNUSED SPACE	0	0	0	0	324,899	193.04
193.05 19305 HEALTH EDUCATION	0	0	0	0	23,557	193.05
193.06 19306 RENTED SPACE	0	0	0	0	699,301	193.06
193.07 19307 AUGUSTA PHARMACY	0	0	0	0	1,082,006	193.07
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

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Cost Center Description	INTERNS & RESIDENTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	Subtotal	
	SERVICES-OTHER PRGM COSTS					
	22.00	23.00	23.01	23.02	24.00	
202.00 TOTAL (sum lines 118-201)	2,636,479	0	300,406	120,681	204,726,050	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING		1.01
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT		1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT		1.03
1.04	00104	CAP REL COSTS-14TH STREET		1.04
1.05	00105	CAP REL COSTS-MOB PHASE I		1.05
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY		23.02
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,929,813	30.00
31.00	03100	INTENSIVE CARE UNIT	-124,394	31.00
40.00	04000	SUBPROVIDER - IPF	-210,437	40.00
41.00	04100	SUBPROVIDER - IRF	-133,932	41.00
43.00	04300	NURSERY	-76,504	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-251,967	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	-9,538	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-9,538	54.00
60.00	06000	LABORATORY	-47,890	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-165,726	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	-353,907	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,313,646	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	FASTCARE	0	192.01
193.00	19300	NONPAID WORKERS	0	193.00
193.02	19302	DENMAN SERVICES	0	193.02
193.03	19303	MEALS ON WHEELS	0	193.03
193.04	19304	UNUSED SPACE	0	193.04
193.05	19305	HEALTH EDUCATION	0	193.05
193.06	19306	RENTED SPACE	0	193.06
193.07	19307	AUGUSTA PHARMACY	0	193.07
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00

COST ALLOCATION -- GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2012
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Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
202.00	TOTAL (sum lines 118-201)	-4,313,646	200,412,404	
				202.00

Provider CCN: 140015 Period: From 10/01/2012 To 09/30/2013 worksheet Non-CMS W
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Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	31	SQUARE FEET	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	32	SQUARE FEET	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	33	SQUARE FEET	1.03
1.04	CAP REL COSTS-14TH STREET	34	SQUARE FEET	1.04
1.05	CAP REL COSTS-MOB PHASE I	35	SQUARE FEET	1.05
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	6	SQUARE FEET	6.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	9	HOURS OF SERVICE	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	11	MEALS SERVED	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NURS. HRS.	13.00
16.00	MEDICAL RECORDS & LIBRARY	16	TIME SPENT	16.00
20.00	NURSING SCHOOL	20	ASSIGNED TIME	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	21	ASSIGNED TIME	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	21	ASSIGNED TIME	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	23	ASSIGNED TIME	23.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			
		BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT
	0	1.00	1.01	1.02	1.03
GENERAL SERVICE COST CENTERS					
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101 CAP REL COSTS-BUTLER BUILDING					1.01
1.02 00102 CAP REL COSTS-OLD BUILDING & FIXT					1.02
1.03 00103 CAP REL COSTS-NEW BUILDING & FIXT					1.03
1.04 00104 CAP REL COSTS-I4TH STREET					1.04
1.05 00105 CAP REL COSTS-MOB PHASE I					1.05
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	11,625	157,071
5.00 00500 ADMINISTRATIVE & GENERAL	4,466	0	0	63,677	559,074
6.00 00600 MAINTENANCE & REPAIRS	88,470	0	5,858	35,703	388,849
8.00 00800 LAUNDRY & LINEN SERVICE	934	0	0	3,522	0
9.00 00900 HOUSEKEEPING	0	0	0	7,615	2,498
10.00 01000 DIETARY	1,156	0	0	0	77,877
11.00 01100 CAFETERIA	0	0	0	0	23,296
13.00 01300 NURSING ADMINISTRATION	2,950	0	0	5,829	0
16.00 01600 MEDICAL RECORDS & LIBRARY	2,336	0	0	984	48,024
20.00 02000 NURSING SCHOOL	3,646	0	21,952	0	144,663
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
23.01 02301 PARAMED ED PRGM-RADIOLOGY	536	0	0	0	3,503
23.02 02302 PARAMED ED PRGM-LABORATORY	0	0	0	1,022	0
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS	93,812	0	0	15,600	551,120
31.00 03100 INTENSIVE CARE UNIT	20,248	0	0	20,760	83,844
40.00 04000 SUBPROVIDER - IPF	1,806	0	0	0	0
41.00 04100 SUBPROVIDER - IRF	1,036	0	0	1,725	37,564
43.00 04300 NURSERY	0	0	0	0	18,775
44.00 04400 SKILLED NURSING FACILITY	31,574	0	0	0	52,715
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	883,164	0	0	21,764	172,480
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	8,336	0
53.00 05300 ANESTHESIOLOGY	10,786	0	0	1,243	4,602
54.00 05400 RADIOLOGY-DIAGNOSTIC	471,134	0	0	0	228,798
60.00 06000 LABORATORY	140,598	0	0	0	82,588
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	762	0
65.00 06500 RESPIRATORY THERAPY	79,407	0	0	7,968	0
66.00 06600 PHYSICAL THERAPY	0	0	0	4,269	36,098
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	3,251	0
68.00 06800 SPEECH PATHOLOGY	498	0	0	1,101	0
69.00 06900 ELECTROCARDIOLOGY	167,745	0	0	14,401	37,944
70.00 07000 ELECTROENCEPHALOGRAPHY	33,554	0	0	4,328	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	45,947	0	0	0	24,789
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	80,280	0	0	0	43,313
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	638	26,697
74.00 07400 RENAL DIALYSIS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	32,716	0	0	0	0
90.00 09000 CLINIC	39,712	0	0	0	0
91.00 09100 EMERGENCY	2,153	0	0	15,036	120,763
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY	2,181	0	0	0	0
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					
116.00 11600 HOSPICE	125,398	0	0	0	0
118.00 SUBTOTALS (SUM OF LINES 1-117)	2,368,243	0	27,810	251,159	2,926,945
NONREIMBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	5,039	0
192.00 19200 PHYSICIANS' PRIVATE OFFICES	44,925	0	0	0	0
192.01 19201 FASTCARE	70,979	0	0	0	0
193.00 19300 NONPAID WORKERS	0	0	0	0	0
193.02 19302 DENMAN SERVICES	0	0	0	0	6,788
193.03 19303 MEALS ON WHEELS	0	0	0	0	0
193.04 19304 UNUSED SPACE	0	0	0	1,798	1,514
193.05 19305 HEALTH EDUCATION	0	0	0	0	0
193.06 19306 RENTED SPACE	0	0	0	840	106,848
193.07 19307 AUGUSTA PHARMACY	0	0	0	0	0
200.00 Cross Foot Adjustments					

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
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Date/Time Prepared:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT	
201.00	Negative Cost Centers	0	1.00	1.01	1.02	1.03	201.00
202.00	TOTAL (sum lines 118-201)	2,484,147	0	27,810	258,836	3,042,095	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	14TH STREET	MOB PHASE I	MVBLE EQUIP			
	1.04	1.05	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02 00102	CAP REL COSTS-OLD BUILDING & FIXT					1.02
1.03 00103	CAP REL COSTS-NEW BUILDING & FIXT					1.03
1.04 00104	CAP REL COSTS-14TH STREET					1.04
1.05 00105	CAP REL COSTS-MOB PHASE I					1.05
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	483	0	153,370	322,549	322,549 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	71,615	0	3,597,461	4,296,293	34,561 5.00
6.00 00600	MAINTENANCE & REPAIRS	65,183	0	182,198	766,261	8,539 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	403	0	4,005	8,864	217 8.00
9.00 00900	HOUSEKEEPING	2,817	0	97,761	110,691	7,351 9.00
10.00 01000	DIETARY	4,263	0	84,030	167,326	2,105 10.00
11.00 01100	CAFETERIA	5,481	0	0	28,777	5,612 11.00
13.00 01300	NURSING ADMINISTRATION	3,330	0	847,277	859,386	18,944 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,213	0	291,098	343,655	6,674 16.00
20.00 02000	NURSING SCHOOL	8,100	0	51,989	230,350	12,640 20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	3,790 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	18	18	0 22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
23.01 02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	4,039	830 23.01
23.02 02302	PARAMED ED PRGM-LABORATORY	0	0	0	1,022	300 23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	0	229,884	890,416	46,180 30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	87,416	212,268	11,301 31.00
40.00 04000	SUBPROVIDER - IPF	25,746	0	16,840	44,392	13,147 40.00
41.00 04100	SUBPROVIDER - IRF	0	0	26,250	66,575	4,887 41.00
43.00 04300	NURSERY	0	0	10,418	29,193	1,299 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	2,669	86,958	4,993 44.00
ANCLLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	42,661	1,577,888	2,697,957	24,010 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	31,138	39,474	3,830 52.00
53.00 05300	ANESTHESIOLOGY	0	0	177,206	193,837	578 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	17,346	1,890,357	2,607,635	16,883 54.00
60.00 06000	LABORATORY	360	0	282,185	505,731	10,535 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	762	415 62.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	87,375	6,742 65.00
66.00 06600	PHYSICAL THERAPY	0	0	8,239	48,606	4,809 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	2,924	6,175	1,866 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	1,817	3,416	863 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	575,696	795,786	5,133 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	21,493	59,375	882 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,246	0	38,639	114,621	865 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	9,167	0	46,825	179,585	1,511 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	350	0	267,144	294,829	11,131 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	32,716	1,480 88.00
90.00 09000	CLINIC	0	0	0	39,712	450 90.00
91.00 09100	EMERGENCY	8,638	0	84,902	231,492	13,606 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	5,274	0	17,223	24,678	13,555 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
116.00 11600	HOSPICE	3,977	0	8,633	138,008	5,568 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	221,646	60,007	10,714,993	16,570,803	308,102 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,363	0	0	8,402	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	21,617	0	351	66,893	12,182 192.00
192.01 19201	FASTCARE	0	0	7,085	78,064	1,622 192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
193.02 19302	DENMAN SERVICES	2,034	0	287	9,109	0 193.02
193.03 19303	MEALS ON WHEELS	0	0	0	0	0 193.03
193.04 19304	UNUSED SPACE	17,602	0	0	20,914	0 193.04
193.05 19305	HEALTH EDUCATION	0	0	0	0	51 193.05
193.06 19306	RENTED SPACE	10,631	0	0	118,319	0 193.06
193.07 19307	AUGUSTA PHARMACY	0	0	237	237	592 193.07
200.00	Cross Foot Adjustments	0	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

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Part II
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Cost Center Description	CAPITAL RELATED COSTS			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	14TH STREET	MOB PHASE I	MVBLE EQUIP			
	1.04	1.05	2.00			
202.00 TOTAL (sum lines 118-201)	276,893	60,007	10,722,953	16,872,741	322,549	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00104						1.04
1.05	00105						1.05
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	4,330,854					5.00
6.00	00600	185,593	960,393				6.00
8.00	00800	27,855	4,008	40,944			8.00
9.00	00900	74,850	12,730		98	205,720	9.00
10.00	01000	29,345	28,740	242	2,860	230,618	10.00
11.00	01100	78,058	15,903	0	6,268	0	11.00
13.00	01300	219,353	11,259	0	3,000	0	13.00
16.00	01600	95,910	16,189	0	2,221	0	16.00
20.00	02000	72,527	80,335	0	5,892	0	20.00
21.00	02100	35,479	0	0	0	0	21.00
22.00	02200	54,608	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
23.01	02301	5,883	960	0	122	0	23.01
23.02	02302	2,292	960	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	485,453	165,644	18,350	51,969	127,341	30.00
31.00	03100	112,417	42,471	1,958	14,947	15,392	31.00
40.00	04000	126,900	44,717	1,421	13,463	46,755	40.00
41.00	04100	53,859	11,912	1,204	5,225	19,344	41.00
43.00	04300	14,011	5,144	152	1,376	0	43.00
44.00	04400	51,363	14,443	923	4,874	21,786	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	386,741	83,130	5,482	24,740	0	50.00
52.00	05200	47,756	7,829	692	5,458	0	52.00
53.00	05300	16,774	2,429	0	0	0	53.00
54.00	05400	269,518	68,961	3,257	10,180	0	54.00
60.00	06000	178,069	23,252	61	3,713	0	60.00
62.00	06200	33,350	716	0	60	0	62.00
65.00	06500	69,440	7,484	27	4,099	0	65.00
66.00	06600	49,506	13,900	1	3,237	0	66.00
67.00	06700	17,911	3,054	0	0	0	67.00
68.00	06800	8,231	1,034	0	0	0	68.00
69.00	06900	84,340	23,922	731	1,562	0	69.00
70.00	07000	9,642	4,065	246	747	0	70.00
71.00	07100	192,930	15,903	219	1,352	0	71.00
72.00	07200	279,102	27,788	383	2,364	0	72.00
73.00	07300	362,532	8,521	0	1,815	0	73.00
74.00	07400	15,345	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	25,155	0	0	36	0	88.00
90.00	09000	5,328	0	0	0	0	90.00
91.00	09100	154,105	62,212	5,296	18,273	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	165,651	9,159	0	7,336	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	67,356	6,907	59	1,291	0	116.00
118.00		4,164,538	825,681	40,802	198,480	230,618	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	224	10,574	140	0	0	190.00
192.00	19200	120,414	37,544	2	0	0	192.00
192.01	19201	18,347	0	0	0	0	192.01
193.00	19300	0	0	0	0	0	193.00
193.02	19302	243	5,393	0	1,243	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	559	32,675	0	0	0	193.04
193.05	19305	480	0	0	0	0	193.05
193.06	19306	3,160	48,526	0	5,997	0	193.06
193.07	19307	22,889	0	0	0	0	193.07
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		4,330,854	960,393	40,944	205,720	230,618	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part II
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES	
		11.00	13.00	16.00	20.00	21.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00104						1.04
1.05	00105						1.05
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	134,618					11.00
13.00	01300	9,963	1,121,905				13.00
16.00	01600	5,196		469,845			16.00
20.00	02000	6,677	0	0	408,421		20.00
21.00	02100	0	0	0		39,269	21.00
22.00	02200	1,877	0	0			22.00
23.00	02300	0	0	0			23.00
23.01	02301	388	0	0			23.01
23.02	02302	122	0	0			23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	26,295	383,738	257,271			30.00
31.00	03100	5,523	80,599	31,098			31.00
40.00	04000	7,689	112,220	39,083			40.00
41.00	04100	2,608	38,055	94,461			41.00
43.00	04300	537	7,844	1,121			43.00
44.00	04400	3,064	44,715	44,014			44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	13,082	190,913	0			50.00
52.00	05200	1,841	26,869	0			52.00
53.00	05300	429	6,268	0			53.00
54.00	05400	8,188	0	0			54.00
60.00	06000	6,814	0	0			60.00
62.00	06200	230	0	0			62.00
65.00	06500	3,576	0	0			65.00
66.00	06600	1,881	0	0			66.00
67.00	06700	839	0	0			67.00
68.00	06800	318	0	0			68.00
69.00	06900	2,435	0	0			69.00
70.00	07000	587	0	0			70.00
71.00	07100	823	0	0			71.00
72.00	07200	1,439	0	0			72.00
73.00	07300	4,436	0	0			73.00
74.00	07400	0	0	0			74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0			88.00
90.00	09000	227	0	0			90.00
91.00	09100	7,134	104,116	2,797			91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	5,334	77,841	0			101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	2,977	43,447	0			116.00
118.00		132,529	1,116,625	469,845	0	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0			190.00
192.00	19200	2,060	0	0			192.00
192.01	19201	0	5,280	0			192.01
193.00	19300	0	0	0			193.00
193.02	19302	0	0	0			193.02
193.03	19303	0	0	0			193.03
193.04	19304	0	0	0			193.04
193.05	19305	29	0	0			193.05
193.06	19306	0	0	0			193.06
193.07	19307	0	0	0			193.07
200.00					408,421	39,269	200.00
201.00		0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part II
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Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	INTERNS & RESIDENTS	SERVICES-SALAR Y & FRINGES
		11.00	13.00	16.00	20.00	21.00
202.00 TOTAL (sum lines 118-201)	134,618	1,121,905	469,845	408,421	39,269	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	INTERNS & RESIDENTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	Subtotal
	SERVICES-OTHER PRGM COSTS				
	22.00				
GENERAL SERVICE COST CENTERS					
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101 CAP REL COSTS-BUTLER BUILDING					1.01
1.02 00102 CAP REL COSTS-OLD BUILDING & FIXT					1.02
1.03 00103 CAP REL COSTS-NEW BUILDING & FIXT					1.03
1.04 00104 CAP REL COSTS-14TH STREET					1.04
1.05 00105 CAP REL COSTS-MOB PHASE I					1.05
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500 ADMINISTRATIVE & GENERAL					5.00
6.00 00600 MAINTENANCE & REPAIRS					6.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9.00 00900 HOUSEKEEPING					9.00
10.00 01000 DIETARY					10.00
11.00 01100 CAFETERIA					11.00
13.00 01300 NURSING ADMINISTRATION					13.00
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00
20.00 02000 NURSING SCHOOL					20.00
21.00 02100 T&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00 02200 T&R SERVICES-OTHER PRGM COSTS APPRVD	56,503	0			22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)		0			23.00
23.01 02301 PARAMED ED PRGM-RADIOLOGY			12,222		23.01
23.02 02302 PARAMED ED PRGM-LABORATORY				4,696	23.02
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS					2,452,657 30.00
31.00 03100 INTENSIVE CARE UNIT					527,974 31.00
40.00 04000 SUBPROVIDER - IPF					449,787 40.00
41.00 04100 SUBPROVIDER - IRF					298,130 41.00
43.00 04300 NURSERY					60,677 43.00
44.00 04400 SKILLED NURSING FACILITY					277,133 44.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM					3,426,055 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM					133,749 52.00
53.00 05300 ANESTHESIOLOGY					220,315 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC					2,984,622 54.00
60.00 06000 LABORATORY					728,175 60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS					35,533 62.00
65.00 06500 RESPIRATORY THERAPY					178,743 65.00
66.00 06600 PHYSICAL THERAPY					121,940 66.00
67.00 06700 OCCUPATIONAL THERAPY					29,865 67.00
68.00 06800 SPEECH PATHOLOGY					13,862 68.00
69.00 06900 ELECTROCARDIOLOGY					913,909 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY					75,544 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS					326,713 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS					492,172 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS					683,264 73.00
74.00 07400 RENAL DIALYSIS					15,345 74.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					59,387 88.00
90.00 09000 CLINIC					45,717 90.00
91.00 09100 EMERGENCY					599,031 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY					303,554 101.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
116.00 11600 HOSPICE					265,613 116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	15,719,466 118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					19,340 190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES					239,095 192.00
192.01 19201 FASTCARE					103,313 192.01
193.00 19300 NONPAID WORKERS					0 193.00
193.02 19302 DENMAN SERVICES					15,988 193.02
193.03 19303 MEALS ON WHEELS					0 193.03
193.04 19304 UNUSED SPACE					54,148 193.04
193.05 19305 HEALTH EDUCATION					560 193.05
193.06 19306 RENTED SPACE					176,002 193.06
193.07 19307 AUGUSTA PHARMACY					23,718 193.07
200.00 Cross Foot Adjustments	56,503	0	12,222	4,696	521,111 200.00
201.00 Negative Cost Centers	0	0	0	0	0 201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	INTERNS & RESIDENTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	Subtotal
	SERVICES-OTHER PRGM COSTS				
	22.00	23.00	23.01	23.02	24.00
202.00 TOTAL (sum lines 118-201)	56,503	0	12,222	4,696	16,872,741 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

worksheet B
Part II
Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING		1.01
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT		1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT		1.03
1.04	00104	CAP REL COSTS-14TH STREET		1.04
1.05	00105	CAP REL COSTS-MOB PHASE I		1.05
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY		23.02
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0 2,452,657	30.00
31.00	03100	INTENSIVE CARE UNIT	0 527,974	31.00
40.00	04000	SUBPROVIDER - IPF	0 449,787	40.00
41.00	04100	SUBPROVIDER - IRF	0 298,130	41.00
43.00	04300	NURSERY	0 60,677	43.00
44.00	04400	SKILLED NURSING FACILITY	0 277,133	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0 3,426,055	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0 133,749	52.00
53.00	05300	ANESTHESIOLOGY	0 220,315	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0 2,984,622	54.00
60.00	06000	LABORATORY	0 728,175	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0 35,533	62.00
65.00	06500	RESPIRATORY THERAPY	0 178,743	65.00
66.00	06600	PHYSICAL THERAPY	0 121,940	66.00
67.00	06700	OCCUPATIONAL THERAPY	0 29,865	67.00
68.00	06800	SPEECH PATHOLOGY	0 13,862	68.00
69.00	06900	ELECTROCARDIOLOGY	0 913,909	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0 75,544	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0 326,713	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0 492,172	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0 683,264	73.00
74.00	07400	RENAL DIALYSIS	0 15,345	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0 59,387	88.00
90.00	09000	CLINIC	0 45,717	90.00
91.00	09100	EMERGENCY	0 599,031	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0 303,554	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	0 265,613	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0 15,719,466	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 19,340	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0 239,095	192.00
192.01	19201	FASTCARE	0 103,313	192.01
193.00	19300	NONPAID WORKERS	0 0	193.00
193.02	19302	DENMAN SERVICES	0 15,988	193.02
193.03	19303	MEALS ON WHEELS	0 0	193.03
193.04	19304	UNUSED SPACE	0 54,148	193.04
193.05	19305	HEALTH EDUCATION	0 560	193.05
193.06	19306	RENTED SPACE	0 176,002	193.06
193.07	19307	AUGUSTA PHARMACY	0 23,718	193.07
200.00		Cross Foot Adjustments	0 521,111	200.00
201.00		Negative Cost Centers	0 0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Intern & Residents Cost & Post-Stepdown Adjustments	Total		
202.00	TOTAL (sum lines 118-201)	0	16,872,741	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet B-1

Date/Time Prepared:
2/28/2014 2:15 pm

CAPITAL RELATED COSTS						
Cost Center Description	BLDG & FIXT	BUTLER	OLD BUILDING &	NEW BUILDING &	14TH STREET	
	(SQUARE FEET)	BUILDING	FIXT	FIXT	(SQUARE FEET)	
	1.00	1.01	1.02	1.03	1.04	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	0				1.00
1.01 00101	CAP REL COSTS-BUTLER BUILDING	0	18,141			1.01
1.02 00102	CAP REL COSTS-OLD BUILDING & FIXT	0	0	130,725		1.02
1.03 00103	CAP REL COSTS-NEW BUILDING & FIXT	0	0	0	448,167	1.03
1.04 00104	CAP REL COSTS-14TH STREET	0	0	0	258,594	1.04
1.05 00105	CAP REL COSTS-MOB PHASE I	0	0	0	0	1.05
2.00 00200	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	5,871	23,140	451 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	0	32,160	82,364	66,883 5.00
6.00 00600	MAINTENANCE & REPAIRS	0	3,821	18,032	57,286	60,875 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	1,779	0	376 8.00
9.00 00900	HOUSEKEEPING	0	0	3,846	368	2,631 9.00
10.00 01000	DIETARY	0	0	0	11,473	3,981 10.00
11.00 01100	CAFETERIA	0	0	0	3,432	5,119 11.00
13.00 01300	NURSING ADMINISTRATION	0	0	2,944	0	3,110 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	497	7,075	1,133 16.00
20.00 02000	NURSING SCHOOL	0	14,320	0	21,312	7,565 20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0 22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
23.01 02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	516	0 23.01
23.02 02302	PARAMED ED PRGM-LABORATORY	0	0	516	0	0 23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	0	7,879	81,192	0 30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	10,485	12,352	0 31.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	24,045 40.00
41.00 04100	SUBPROVIDER - IRF	0	0	871	5,534	0 41.00
43.00 04300	NURSERY	0	0	0	2,766	0 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	7,766	0 44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	10,992	25,410	0 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	4,210	0	0 52.00
53.00 05300	ANESTHESIOLOGY	0	0	628	678	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	33,707	0 54.00
60.00 06000	LABORATORY	0	0	0	12,167	336 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	385	0	0 62.00
65.00 06500	RESPIRATORY THERAPY	0	0	4,024	0	0 65.00
66.00 06600	PHYSICAL THERAPY	0	0	2,156	5,318	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	1,642	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	556	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	7,273	5,590	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	2,186	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,652	4,899 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,381	8,561 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	322	3,933	327 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	0	0	7,594	17,791	8,067 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	4,925 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
116.00 11600	HOSPICE	0	0	0	0	3,714 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	18,141	126,848	431,203	206,998 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,545	0	3,141 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	20,188 192.00
192.01 19201	FASTCARE	0	0	0	0	0 192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
193.02 19302	DENMAN SERVICES	0	0	0	1,000	1,900 193.02
193.03 19303	MEALS ON WHEELS	0	0	0	0	0 193.03
193.04 19304	UNUSED SPACE	0	0	908	223	16,439 193.04
193.05 19305	HEALTH EDUCATION	0	0	0	0	0 193.05
193.06 19306	RENTED SPACE	0	0	424	15,741	9,928 193.06
193.07 19307	AUGUSTA PHARMACY	0	0	0	0	0 193.07
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet B-1

Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BUILDING & FIXT (SQUARE FEET)	NEW BUILDING & FIXT (SQUARE FEET)	14TH STREET (SQUARE FEET)	
		1.00	1.01	1.02	1.03	1.04	
202.00	Cost to be allocated (per Wkst. B, Part I)	0	27,810	258,836	3,042,095	276,893	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	1.532992	1.980004	6.787860	1.070763	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)						204.00
205.00	Unit cost multiplier (Wkst. B, Part II)						205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet B-1

Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	MOB PHASE I (SQ. FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.05	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02 00102	CAP REL COSTS-OLD BUILDING & FIXT						1.02
1.03 00103	CAP REL COSTS-NEW BUILDING & FIXT						1.03
1.04 00104	CAP REL COSTS-14TH STREET						1.04
1.05 00105	CAP REL COSTS-MOB PHASE I	11,672					1.05
2.00 00200	CAP REL COSTS-MVBLE EQUIP		10,740,926				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT		153,627	91,367,443			4.00
5.00 00500	ADMINISTRATIVE & GENERAL		3,603,495	9,790,632	-42,559,825	162,166,225	5.00
6.00 00600	MAINTENANCE & REPAIRS		182,503	2,419,069		6,949,505	6.00
8.00 00800	LAUNDRY & LINEN SERVICE		4,012	61,611		1,043,023	8.00
9.00 00900	HOUSEKEEPING		97,925	2,082,453		2,802,750	9.00
10.00 01000	DIETARY		84,171	596,297		1,098,799	10.00
11.00 01100	CAFETERIA			1,589,705		2,922,871	11.00
13.00 01300	NURSING ADMINISTRATION		848,697	5,366,669		8,213,638	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY		291,586	1,890,567		3,591,340	16.00
20.00 02000	NURSING SCHOOL		52,076	3,580,803		2,715,743	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD			1,073,548		1,328,506	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		18			2,044,801	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)					0	23.00
23.01 02301	PARAMED ED PRGM-RADIOLOGY			235,081		220,286	23.01
23.02 02302	PARAMED ED PRGM-LABORATORY			84,892		85,826	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS		230,269	13,075,544		18,175,936	30.00
31.00 03100	INTENSIVE CARE UNIT		87,562	3,201,479		4,209,423	31.00
40.00 04000	SUBPROVIDER - IPF		16,868	3,724,272		4,751,724	40.00
41.00 04100	SUBPROVIDER - IRF		26,294	1,384,280		2,016,739	41.00
43.00 04300	NURSERY		10,435	367,982		524,650	43.00
44.00 04400	SKILLED NURSING FACILITY		2,673	1,414,469		1,923,292	44.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	8,298	1,580,532	6,801,647		14,481,442	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM		31,190	1,085,062		1,788,196	52.00
53.00 05300	ANESTHESIOLOGY		177,503	163,733		628,111	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,374	1,893,525	4,782,740		10,092,037	54.00
60.00 06000	LABORATORY		282,658	2,984,357		6,667,765	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS			117,612		1,248,801	62.00
65.00 06500	RESPIRATORY THERAPY			1,909,998		2,600,172	65.00
66.00 06600	PHYSICAL THERAPY		8,253	1,362,333		1,853,730	66.00
67.00 06700	OCCUPATIONAL THERAPY		2,929	534,182		670,686	67.00
68.00 06800	SPEECH PATHOLOGY		1,820	244,531		308,196	68.00
69.00 06900	ELECTROCARDIOLOGY		576,661	1,454,179		3,158,093	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY		21,529	249,934		361,037	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		38,704	244,973		7,224,227	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS		46,903	428,029		10,450,917	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS		267,592	3,153,313		13,574,916	73.00
74.00 07400	RENAL DIALYSIS					574,602	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC			419,334		941,938	88.00
90.00 09000	CLINIC			127,593		199,509	90.00
91.00 09100	EMERGENCY		85,044	3,854,451		5,770,430	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY		17,252	3,839,939		6,202,775	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
116.00 11600	HOSPICE		8,647	1,577,437		2,522,130	116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	11,672	10,732,953	87,274,730	-42,559,825	155,938,562	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN					8,402	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES		352	3,451,052		4,508,875	192.00
192.01 19201	FASTCARE		7,097	459,574		686,988	192.01
193.00 19300	NONPAID WORKERS					0	193.00
193.02 19302	DENMAN SERVICES		287			9,109	193.02
193.03 19303	MEALS ON WHEELS					0	193.03
193.04 19304	UNUSED SPACE					20,914	193.04
193.05 19305	HEALTH EDUCATION			14,499		17,985	193.05
193.06 19306	RENTED SPACE					118,319	193.06
193.07 19307	AUGUSTA PHARMACY		237	167,588		857,071	193.07

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

worksheet B-1

Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		CAPITAL RELATED COSTS			Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		MOB PHASE I (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)			
		1.05	2.00	4.00			
200.00	Cross Foot Adjustments				5A	5.00	200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	60,007	10,722,953	21,698,957		42,559,825	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	5.141107	0.998327	0.237491		0.262446	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			322,549		4,330,854	204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.003530		0.026706	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet B-1
Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		6.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00104						1.04
1.05	00105						1.05
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	516,416					6.00
8.00	00800	2,155	1,565,893				8.00
9.00	00900	6,845	3,756	103,283			9.00
10.00	01000	15,454	9,244	1,436	171,282		10.00
11.00	01100	8,551	0	3,147	0	435,210	11.00
13.00	01300	6,054	0	1,506	0	32,210	13.00
16.00	01600	8,705	0	1,115	0	16,797	16.00
20.00	02000	43,197	0	2,958	0	21,585	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	6,068	22.00
23.00	02300	0	0	0	0	0	23.00
23.01	02301	516	0	61	0	1,255	23.01
23.02	02302	516	0	0	0	393	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	89,071	701,865	26,093	94,577	85,006	30.00
31.00	03100	22,837	74,877	7,504	11,432	17,855	31.00
40.00	04000	24,045	54,332	6,759	34,725	24,859	40.00
41.00	04100	6,405	46,057	2,623	14,367	8,430	41.00
43.00	04300	2,766	5,805	691	0	1,737	43.00
44.00	04400	7,766	35,308	2,447	16,181	9,905	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	44,700	209,653	12,421	0	42,292	50.00
52.00	05200	4,210	26,447	2,740	0	5,952	52.00
53.00	05300	1,306	0	0	0	1,388	53.00
54.00	05400	37,081	124,547	5,111	0	26,471	54.00
60.00	06000	12,503	2,334	1,864	0	22,028	60.00
62.00	06200	385	0	30	0	745	62.00
65.00	06500	4,024	1,038	2,058	0	11,562	65.00
66.00	06600	7,474	33	1,625	0	6,081	66.00
67.00	06700	1,642	0	0	0	2,713	67.00
68.00	06800	556	0	0	0	1,029	68.00
69.00	06900	12,863	27,951	784	0	7,873	69.00
70.00	07000	2,186	9,412	375	0	1,899	70.00
71.00	07100	8,551	8,380	679	0	2,662	71.00
72.00	07200	14,942	14,643	1,187	0	4,652	72.00
73.00	07300	4,582	0	911	0	14,342	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	18	0	0	88.00
90.00	09000	0	0	0	0	734	90.00
91.00	09100	33,452	202,529	9,174	0	23,064	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	4,925	0	3,683	0	17,244	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	3,714	2,268	648	0	9,625	116.00
118.00		443,979	1,560,479	99,648	171,282	428,456	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	5,686	5,353	0	0	0	190.00
192.00	19200	20,188	61	0	0	6,660	192.00
192.01	19201	0	0	0	0	0	192.01
193.00	19300	0	0	0	0	0	193.00
193.02	19302	2,900	0	624	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	17,570	0	0	0	0	193.04
193.05	19305	0	0	0	0	94	193.05
193.06	19306	26,093	0	3,011	0	0	193.06
193.07	19307	0	0	0	0	0	193.07
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet B-1

Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		6.00	8.00	9.00	10.00	11.00	
202.00	Cost to be allocated (per wkst. B, Part I)	8,773,375	1,353,371	3,657,856	1,708,568	3,946,694	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	16.988968	0.864281	35.415857	9.975175	9.068482	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	960,393	40,944	205,720	230,618	134,618	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	1.859727	0.026147	1.991809	1.346423	0.309317	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

worksheet B-1

Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		
				SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	
				13.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02 00102	CAP REL COSTS-OLD BUILDING & FIXT					1.02
1.03 00103	CAP REL COSTS-NEW BUILDING & FIXT					1.03
1.04 00104	CAP REL COSTS-14TH STREET					1.04
1.05 00105	CAP REL COSTS-MOB PHASE I					1.05
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION	1,649,488				13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	113,570			16.00
20.00 02000	NURSING SCHOOL	0	0	32,602		20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	21,708	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
23.01 02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	23.01
23.02 02302	PARAMED ED PRGM-LABORATORY	0	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	564,191	62,187	24,001	14,744	14,744
31.00 03100	INTENSIVE CARE UNIT	118,502	7,517	1,036	626	626
40.00 04000	SUBPROVIDER - IPF	164,993	9,447	2,361	1,059	1,059
41.00 04100	SUBPROVIDER - IRF	55,950	22,833	0	674	674
43.00 04300	NURSERY	11,532	271	467	385	385
44.00 04400	SKILLED NURSING FACILITY	65,742	10,639	1,366	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	280,691	0	1,114	1,268	1,268
52.00 05200	DELIVERY ROOM & LABOR ROOM	39,505	0	1,366	0	0
53.00 05300	ANESTHESIOLOGY	9,215	0	0	48	48
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	48	48
60.00 06000	LABORATORY	0	0	0	241	241
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00 06600	PHYSICAL THERAPY	0	0	0	0	0
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00 06900	ELECTROCARDIOLOGY	0	0	60	834	834
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	153,078	676	733	1,781	1,781
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	114,447	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
116.00 11600	HOSPICE	63,879	0	98	0	0
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	1,641,725	113,570	32,602	21,708	21,708
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01 19201	FASTCARE	7,763	0	0	0	0
193.00 19300	NONPAID WORKERS	0	0	0	0	0
193.02 19302	DENMAN SERVICES	0	0	0	0	0
193.03 19303	MEALS ON WHEELS	0	0	0	0	0
193.04 19304	UNUSED SPACE	0	0	0	0	0
193.05 19305	HEALTH EDUCATION	0	0	0	0	0
193.06 19306	RENTED SPACE	0	0	0	0	0
193.07 19307	AUGUSTA PHARMACY	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet B-1

Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		
				SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	
				13.00	16.00	
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	10,817,557	4,873,574	4,462,854	1,677,167	2,636,479
203.00	Unit cost multiplier (Wkst. B, Part I)	6.558130	42.912512	136.888964	77.260319	121.451953
204.00	Cost to be allocated (per Wkst. B, Part II)	1,121,905	469,845	408,421	39,269	56,503
205.00	Unit cost multiplier (Wkst. B, Part II)	0.680153	4.137052	12.527483	1.808964	2.602865

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)	
		23.00	23.01	23.02	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING			1.01
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT			1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT			1.03
1.04	00104	CAP REL COSTS-14TH STREET			1.04
1.05	00105	CAP REL COSTS-MOB PHASE I			1.05
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	100	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	100	23.02
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	100	54.00
60.00	06000	LABORATORY	0	100	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	100	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	FASTCARE	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
193.02	19302	DENMAN SERVICES	0	0	193.02
193.03	19303	MEALS ON WHEELS	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	193.04
193.05	19305	HEALTH EDUCATION	0	0	193.05
193.06	19306	RENTED SPACE	0	0	193.06
193.07	19307	AUGUSTA PHARMACY	0	0	193.07
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet B-1
Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATOR Y (ASSIGNED TIME)	
		23,00	23,01	23,02	
202.00	Cost to be allocated (per wkst. B, Part I)	0	300,406	120,681	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	0.000000	3,004.060000	1,206.810000	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	0	12,222	4,696	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.000000	122.220000	46.960000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, Col. 26)	Therapy Limit Adj.	Hospital		PPS
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	37,358,439		37,358,439	7,887	37,366,326 30.00
31.00	03100 INTENSIVE CARE UNIT	7,550,118		7,550,118	0	7,550,118 31.00
40.00	04000 SUBPROVIDER - IPF	9,076,086		9,076,086	0	9,076,086 40.00
41.00	04100 SUBPROVIDER - IRF	4,354,048		4,354,048	14,115	4,368,163 41.00
43.00	04300 NURSERY	905,758		905,758	0	905,758 43.00
44.00	04400 SKILLED NURSING FACILITY	4,003,079		4,003,079	755	4,003,834 44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	22,039,371		22,039,371	62,187	22,101,558 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,948,967		2,948,967	0	2,948,967 52.00
53.00	05300 ANESTHESIOLOGY	888,164		888,164	0	888,164 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	14,199,732		14,199,732	0	14,199,732 54.00
60.00	06000 LABORATORY	9,018,580		9,018,580	0	9,018,580 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,590,903		1,590,903	0	1,590,903 62.00
65.00	06500 RESPIRATORY THERAPY	3,529,574	0	3,529,574	9,658	3,539,232 65.00
66.00	06600 PHYSICAL THERAPY	2,579,935	0	2,579,935	0	2,579,935 66.00
67.00	06700 OCCUPATIONAL THERAPY	899,204	0	899,204	0	899,204 67.00
68.00	06800 SPEECH PATHOLOGY	407,858	0	407,858	0	407,858 68.00
69.00	06900 ELECTROCARDIOLOGY	4,336,984		4,336,984	11,604	4,348,588 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	531,565		531,565	6,840	538,405 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,320,899		9,320,899	0	9,320,899 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	13,544,449		13,544,449	0	13,544,449 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	17,377,765		17,377,765	0	17,377,765 73.00
74.00	07400 RENAL DIALYSIS	725,404		725,404	0	725,404 74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	1,189,783		1,189,783	0	1,189,783 88.00
90.00	09000 CLINIC	258,525		258,525	1,301	259,826 90.00
91.00	09100 EMERGENCY	9,695,527		9,695,527	192,622	9,888,149 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7,419,638		7,419,638		7,419,638 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	8,951,711		8,951,711		8,951,711 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
116.00	11600 HOSPICE	3,791,685		3,791,685		3,791,685 116.00
200.00	subtotal (see instructions)	198,493,751	0	198,493,751	306,969	198,800,720 200.00
201.00	Less observation Beds	7,419,638		7,419,638		7,419,638 201.00
202.00	Total (see instructions)	191,074,113	0	191,074,113	306,969	191,381,082 202.00

Cost Center Description		Charges			Hospital	PPS	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)				Cost or Other Ratio
		6.00	7.00	8.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	51,967,727		51,967,727			30.00
31.00	03100	INTENSIVE CARE UNIT	24,488,100		24,488,100			31.00
40.00	04000	SUBPROVIDER - IPF	21,891,667		21,891,667			40.00
41.00	04100	SUBPROVIDER - IRF	5,084,512		5,084,512			41.00
43.00	04300	NURSERY	2,783,131		2,783,131			43.00
44.00	04400	SKILLED NURSING FACILITY	4,616,254		4,616,254			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	23,505,527	48,815,801	72,321,328	0.304742	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,961,426	570,306	5,531,732	0.533100	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	6,102,245	9,078,765	15,181,010	0.058505	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,496,796	77,147,695	104,644,491	0.135695	0.000000	54.00
60.00	06000	LABORATORY	31,021,131	44,276,351	75,297,482	0.119773	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,756,843	1,131,845	3,888,688	0.409110	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	8,142,058	2,736,926	10,878,984	0.324440	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,613,019	354,537	3,967,556	0.650258	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,272,786	65,475	2,338,261	0.384561	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	916,633	411,542	1,328,175	0.307082	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	27,314,031	31,826,705	59,140,736	0.073333	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	200,290	1,826,812	2,027,102	0.262229	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,872,657	21,752,801	46,625,458	0.199910	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,553,929	12,606,904	34,160,833	0.396491	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,027,282	31,719,450	88,746,732	0.195813	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,218,856	269,650	1,488,506	0.487337	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	747,908	747,908			88.00
90.00	09000	CLINIC	440	104,677	105,117	2.459402	0.000000	90.00
91.00	09100	EMERGENCY	8,660,717	24,727,155	33,387,872	0.290391	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,993,314	17,148,742	19,142,056	0.387609	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	7,389,726	7,389,726			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4,563	4,096,345	4,100,908			116.00
200.00		Subtotal (see instructions)	364,465,934	338,806,118	703,272,052			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	364,465,934	338,806,118	703,272,052			202.00

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.305602		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.533100		52.00
53.00	05300 ANESTHESIOLOGY	0.058505		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135695		54.00
60.00	06000 LABORATORY	0.119773		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.409110		62.00
65.00	06500 RESPIRATORY THERAPY	0.325327		65.00
66.00	06600 PHYSICAL THERAPY	0.650258		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.384561		67.00
68.00	06800 SPEECH PATHOLOGY	0.307082		68.00
69.00	06900 ELECTROCARDIOLOGY	0.073529		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.265603		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.199910		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.396491		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.195813		73.00
74.00	07400 RENAL DIALYSIS	0.487337		74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
90.00	09000 CLINIC	2.471779		90.00
91.00	09100 EMERGENCY	0.296160		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.387609		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/28/2014 2:15 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (From Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		Total Costs
				RCE Disallowance		
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		37,358,439		7,887	37,366,326 30.00
31.00	03100 INTENSIVE CARE UNIT		7,550,118		0	7,550,118 31.00
40.00	04000 SUBPROVIDER - IPF		9,076,086		0	9,076,086 40.00
41.00	04100 SUBPROVIDER - IRF		4,354,048		14,115	4,368,163 41.00
43.00	04300 NURSERY		905,758		0	905,758 43.00
44.00	04400 SKILLED NURSING FACILITY		4,003,079		755	4,003,834 44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		22,039,371		62,187	22,101,558 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		2,948,967		0	2,948,967 52.00
53.00	05300 ANESTHESIOLOGY		888,164		0	888,164 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		14,199,732		0	14,199,732 54.00
60.00	06000 LABORATORY		9,018,580		0	9,018,580 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		1,590,903		0	1,590,903 62.00
65.00	06500 RESPIRATORY THERAPY	0	3,529,574		9,658	3,539,232 65.00
66.00	06600 PHYSICAL THERAPY	0	2,579,935		0	2,579,935 66.00
67.00	06700 OCCUPATIONAL THERAPY	0	899,204		0	899,204 67.00
68.00	06800 SPEECH PATHOLOGY	0	407,858		0	407,858 68.00
69.00	06900 ELECTROCARDIOLOGY		4,336,984		11,604	4,348,588 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		531,565		6,840	538,405 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		9,320,899		0	9,320,899 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		13,544,449		0	13,544,449 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		17,377,765		0	17,377,765 73.00
74.00	07400 RENAL DIALYSIS		725,404		0	725,404 74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		1,189,783		0	1,189,783 88.00
90.00	09000 CLINIC		258,525		1,301	259,826 90.00
91.00	09100 EMERGENCY		9,695,527		192,622	9,888,149 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		7,419,638		0	7,419,638 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY		8,951,711		0	8,951,711 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
116.00	11600 HOSPICE		3,791,685			3,791,685 116.00
200.00	Subtotal (see instructions)	0	198,493,751		306,969	198,800,720 200.00
201.00	Less Observation Beds		7,419,638			7,419,638 201.00
202.00	Total (see instructions)	0	191,074,113		306,969	191,381,082 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/28/2014 2:15 pm

		Title XIX			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
		9.00	10.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	51,967,727		51,967,727		30.00
31.00	03100	INTENSIVE CARE UNIT	24,488,100		24,488,100		31.00
40.00	04000	SUBPROVIDER - IPF	21,891,667		21,891,667		40.00
41.00	04100	SUBPROVIDER - IRF	5,084,512		5,084,512		41.00
43.00	04300	NURSERY	2,783,131		2,783,131		43.00
44.00	04400	SKILLED NURSING FACILITY	4,616,254		4,616,254		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	23,505,527	48,815,801	72,321,328	0.304742	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,961,426	570,306	5,531,732	0.533100	52.00
53.00	05300	ANESTHESIOLOGY	6,102,245	9,078,765	15,181,010	0.058505	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,496,796	77,147,695	104,644,491	0.135695	54.00
60.00	06000	LABORATORY	31,021,131	44,276,351	75,297,482	0.119773	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,756,843	1,131,845	3,888,688	0.409110	62.00
65.00	06500	RESPIRATORY THERAPY	8,142,058	2,736,926	10,878,984	0.324440	65.00
66.00	06600	PHYSICAL THERAPY	3,613,019	354,537	3,967,556	0.650258	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,272,786	65,475	2,338,261	0.384561	67.00
68.00	06800	SPEECH PATHOLOGY	916,633	411,542	1,328,175	0.307082	68.00
69.00	06900	ELECTROCARDIOLOGY	27,314,031	31,826,705	59,140,736	0.073333	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	200,290	1,826,812	2,027,102	0.262229	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,872,657	21,752,801	46,625,458	0.199910	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,553,929	12,606,904	34,160,833	0.396491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,027,282	31,719,450	88,746,732	0.195813	73.00
74.00	07400	RENAL DIALYSIS	1,218,856	269,650	1,488,506	0.487337	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	747,908	747,908	1.590815	88.00
90.00	09000	CLINIC	440	104,677	105,117	2.459402	90.00
91.00	09100	EMERGENCY	8,660,717	24,727,155	33,387,872	0.290391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,993,314	17,148,742	19,142,056	0.387609	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	7,389,726	7,389,726		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	4,563	4,096,345	4,100,908		116.00
200.00		Subtotal (see instructions)	364,465,934	338,806,118	703,272,052		200.00
201.00		Less observation Beds					201.00
202.00		Total (see instructions)	364,465,934	338,806,118	703,272,052		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part I
Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,452,657	0	2,452,657	40,430	60.66	30.00	
31.00	INTENSIVE CARE UNIT	527,974	0	527,974	3,951	133.63	31.00	
40.00	SUBPROVIDER - IPF	449,787	0	449,787	12,068	37.27	40.00	
41.00	SUBPROVIDER - IRF	298,130	0	298,130	4,912	60.69	41.00	
43.00	NURSERY	60,677		60,677	2,410	25.18	43.00	
44.00	SKILLED NURSING FACILITY	277,133		277,133	5,652	49.03	44.00	
200.00	Total (lines 30-199)	4,066,358		4,066,358	69,423		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	20,251	1,228,426					30.00
31.00	INTENSIVE CARE UNIT	2,625	350,779					31.00
40.00	SUBPROVIDER - IPF	2,378	88,628					40.00
41.00	SUBPROVIDER - IRF	3,596	218,241					41.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	4,752	232,991					44.00
200.00	Total (lines 30-199)	33,602	2,119,065					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part II
Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		Capital Related Cost (from Wkst. B; Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	PPS Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,426,055	72,321,328	0.047373	12,434,149	589,043	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	133,749	5,531,732	0.024179	14,635	354	52.00
53.00	05300 ANESTHESIOLOGY	220,315	15,181,010	0.014513	3,293,883	47,804	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,984,622	104,644,491	0.028522	15,348,404	437,767	54.00
60.00	06000 LABORATORY	728,175	75,297,482	0.009671	16,855,210	163,007	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	35,533	3,888,688	0.009138	1,731,478	15,822	62.00
65.00	06500 RESPIRATORY THERAPY	178,743	10,878,984	0.016430	6,597,745	108,401	65.00
66.00	06600 PHYSICAL THERAPY	121,940	3,967,556	0.030734	1,010,225	31,048	66.00
67.00	06700 OCCUPATIONAL THERAPY	29,865	2,338,261	0.012772	447,517	5,716	67.00
68.00	06800 SPEECH PATHOLOGY	13,862	1,328,175	0.010437	285,927	2,984	68.00
69.00	06900 ELECTROCARDIOLOGY	913,909	59,140,736	0.015453	16,067,159	248,286	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	75,544	2,027,102	0.037267	117,947	4,396	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	326,713	46,625,458	0.007007	11,683,131	81,864	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	492,172	34,160,833	0.014407	12,858,441	185,252	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	683,264	88,746,732	0.007699	29,936,134	230,478	73.00
74.00	07400 RENAL DIALYSIS	15,345	1,488,506	0.010309	854,211	8,806	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	59,387	747,908	0.079404	0	0	88.00
90.00	09000 CLINIC	45,717	105,117	0.434915	440	191	90.00
91.00	09100 EMERGENCY	599,031	33,387,872	0.017942	4,412,541	79,170	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	487,010	19,142,056	0.025442	1,456,430	37,054	92.00
200.00	Total (lines 50-199)	11,570,951	580,950,027		135,405,607	2,277,443	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part III Date/Time Prepared: 2/28/2014 2:15 pm
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Cost Center Description	Title XVIII				Hospital	PPS
	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,285,473	0	0	0	3,285,473	30.00
31.00	03100	INTENSIVE CARE UNIT	141,817	0	0	0	141,817	31.00
40.00	04000	SUBPROVIDER - IPF	323,195	0	0	0	323,195	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	63,927	0	0	0	63,927	43.00
44.00	04400	SKILLED NURSING FACILITY	186,990	0	0	0	186,990	44.00
200.00		Total (lines 30-199)	4,001,402	0	0	0	4,001,402	200.00

Cost Center Description	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School
	6.00	7.00	8.00	9.00	11.00

INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	40,430	81.26	20,251	1,645,596	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,951	35.89	2,625	94,211	0	31.00
40.00	04000	SUBPROVIDER - IPF	12,068	26.78	2,378	63,683	0	40.00
41.00	04100	SUBPROVIDER - IRF	4,912	0.00	3,596	0	0	41.00
43.00	04300	NURSERY	2,410	26.53	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	5,652	33.08	4,752	157,196	0	44.00
200.00		Total (lines 30-199)	69,423		33,602	1,960,686	0	200.00

Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost
	12.00	13.00

INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0			0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0			0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0			0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0			0	41.00
43.00	04300	NURSERY	0	0			0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
200.00		Total (lines 30-199)	0	0			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
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Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	152,494	0	0	0	152,494	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	186,990	0	0	0	186,990	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	300,406	0	0	300,406	54.00
60.00	06000	LABORATORY	0	0	120,681	0	0	120,681	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,213	0	0	0	8,213	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	100,340	0	0	0	100,340	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	652,379	0	0	0	652,379	92.00
200.00		Total (lines 50-199)	0	1,100,416	421,087	0	0	1,521,503	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

worksheet D
Part IV
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Cost Center Description		Title XVIII			Hospital		PPS
		Total outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)	Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	152,494	72,321,328	0.002109	0.002109	12,434,149	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	186,990	5,531,732	0.033803	0.033803	14,635	52.00
53.00	05300 ANESTHESIOLOGY	0	15,181,010	0.000000	0.000000	3,293,883	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	300,406	104,644,491	0.002871	0.002871	15,348,404	54.00
60.00	06000 LABORATORY	120,681	75,297,482	0.001603	0.001603	16,855,210	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	3,888,688	0.000000	0.000000	1,731,478	62.00
65.00	06500 RESPIRATORY THERAPY	0	10,878,984	0.000000	0.000000	6,597,745	65.00
66.00	06600 PHYSICAL THERAPY	0	3,967,556	0.000000	0.000000	1,010,225	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,338,261	0.000000	0.000000	447,517	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,328,175	0.000000	0.000000	285,927	68.00
69.00	06900 ELECTROCARDIOLOGY	8,213	59,140,736	0.000139	0.000139	16,067,159	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,027,102	0.000000	0.000000	117,947	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	46,625,458	0.000000	0.000000	11,683,131	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	34,160,833	0.000000	0.000000	12,858,441	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	88,746,732	0.000000	0.000000	29,936,134	73.00
74.00	07400 RENAL DIALYSIS	0	1,488,506	0.000000	0.000000	854,211	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	747,908	0.000000	0.000000	0	88.00
90.00	09000 CLINIC	0	105,117	0.000000	0.000000	440	90.00
91.00	09100 EMERGENCY	100,340	33,387,872	0.003005	0.003005	4,412,541	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	652,379	19,142,056	0.034081	0.034081	1,456,430	92.00
200.00	Total (lines 50-199)	1,521,503	580,950,027			135,405,607	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/28/2014 2:15 pm
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Cost Center Description	Title XVIII			Hospital		PPS
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	26,224	21,563,646	45,478	0	0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	495	5,139	174	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0	3,284,319	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	44,065	27,239,701	78,205	0	0 54.00
60.00	06000 LABORATORY	27,019	1,507,017	2,416	0	0 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	556,728	0	0	0 62.00
65.00	06500 RESPIRATORY THERAPY	0	1,142,183	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	2,233	12,152,121	1,689	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	573,273	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,746,358	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	6,580,971	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	11,645,376	0	0	0 73.00
74.00	07400 RENAL DIALYSIS	0	235,325	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0 88.00
90.00	09000 CLINIC	0	14,774	0	0	0 90.00
91.00	09100 EMERGENCY	13,260	5,798,146	17,423	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	49,637	8,289,013	282,498	0	0 92.00
200.00	Total (lines 50-199)	162,933	109,334,090	427,883	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	PPS
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
60.00	06000 LABORATORY	0	0			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			62.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
74.00	07400 RENAL DIALYSIS	0	0			74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0			88.00
90.00	09000 CLINIC	0	0			90.00
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/28/2014 2:15 pm
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		Title XVIII		Hospital		PPS	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.304742	21,563,646	0	0	6,571,349	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.533100	5,139	0	0	2,740	52.00
53.00	05300 ANESTHESIOLOGY	0.058505	3,284,319	0	0	192,149	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135695	27,239,701	0	0	3,696,291	54.00
60.00	06000 LABORATORY	0.119773	1,507,017	582	0	180,500	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.409110	556,728	0	0	227,763	62.00
65.00	06500 RESPIRATORY THERAPY	0.324440	1,142,183	0	0	370,570	65.00
66.00	06600 PHYSICAL THERAPY	0.650258	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.384561	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.307082	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.073333	12,152,121	0	0	891,151	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.262229	573,273	0	0	150,329	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.199910	8,746,358	0	0	1,748,484	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.396491	6,580,971	0	0	2,609,296	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.195813	11,645,376	0	0	2,280,316	73.00
74.00	07400 RENAL DIALYSIS	0.487337	235,325	0	0	114,683	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000 CLINIC	2.459402	14,774	0	0	36,335	90.00
91.00	09100 EMERGENCY	0.290391	5,798,146	0	0	1,683,729	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.387609	8,289,013	0	0	3,212,896	92.00
200.00	Subtotal (see instructions)		109,334,090	582	0	23,968,581	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		109,334,090	582	0	23,968,581	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part V
Date/Time Prepared:
2/28/2014 2:15 pm

		Title XVIII		Hospital	PPS
Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000 LABORATORY	70	0		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500 RESPIRATORY THERAPY	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0		74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0		88.00
90.00	09000 CLINIC	0	0		90.00
91.00	09100 EMERGENCY	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Subtotal (see instructions)	70	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00	Net Charges (line 200 +/- line 201)	70	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 140015 Component CCN: 14S015		Period: From 10/01/2012 To 09/30/2013		Worksheet D Part II Date/Time Prepared: 2/28/2014 2:15 pm	
Cost Center Description			Capital Related Cost (From wkst. B, Part II, col. 26)	Total Charges (From wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,426,055	72,321,328	0.047373	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	133,749	5,531,732	0.024179	0	0	52.00
53.00	05300	ANESTHESIOLOGY	220,315	15,181,010	0.014513	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,984,622	104,644,491	0.028522	75,687	2,159	54.00
60.00	06000	LABORATORY	728,175	75,297,482	0.009671	480,442	4,646	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	35,533	3,888,688	0.009138	643	6	62.00
65.00	06500	RESPIRATORY THERAPY	178,743	10,878,984	0.016430	21,030	346	65.00
66.00	06600	PHYSICAL THERAPY	121,940	3,967,556	0.030734	3,394	104	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,865	2,338,261	0.012772	650	8	67.00
68.00	06800	SPEECH PATHOLOGY	13,862	1,328,175	0.010437	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	913,909	59,140,736	0.015453	63,289	978	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	75,544	2,027,102	0.037267	2,973	111	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	326,713	46,625,458	0.007007	7,718	54	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	492,172	34,160,833	0.014407	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	683,264	88,746,732	0.007699	340,595	2,622	73.00
74.00	07400	RENAL DIALYSIS	15,345	1,488,506	0.010309	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	59,387	747,908	0.079404	0	0	88.00
90.00	09000	CLINIC	45,717	105,117	0.434915	0	0	90.00
91.00	09100	EMERGENCY	599,031	33,387,872	0.017942	165,124	2,963	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	19,142,056	0.000000	0	0	92.00
200.00		Total (lines 50-199)	11,083,941	580,950,027		1,161,545	13,997	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015
Component CCN: 145015

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	152,494	0	0	152,494	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	186,990	0	0	186,990	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	300,406	0	300,406	54.00
60.00	06000 LABORATORY	0	0	120,681	0	120,681	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	8,213	0	0	8,213	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	100,340	0	0	100,340	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	448,037	421,087	0	869,124	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/28/2014 2:15 pm	
		Component CCN: 14S015	Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (From Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges
	6.00	7.00	8.00	9.00	10.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	152,494	72,321,328	0.002109	0
52.00	05200 DELIVERY ROOM & LABOR ROOM	186,990	5,531,732	0.033803	0
53.00	05300 ANESTHESIOLOGY	0	15,181,010	0.000000	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	300,406	104,644,491	0.002871	75,687
60.00	06000 LABORATORY	120,681	75,297,482	0.001603	480,442
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	3,888,688	0.000000	643
65.00	06500 RESPIRATORY THERAPY	0	10,878,984	0.000000	21,030
66.00	06600 PHYSICAL THERAPY	0	3,967,556	0.000000	3,394
67.00	06700 OCCUPATIONAL THERAPY	0	2,338,261	0.000000	650
68.00	06800 SPEECH PATHOLOGY	0	1,328,175	0.000000	0
69.00	06900 ELECTROCARDIOLOGY	8,213	59,140,736	0.000139	63,289
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,027,102	0.000000	2,973
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	46,625,458	0.000000	7,718
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	34,160,833	0.000000	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0	88,746,732	0.000000	340,595
74.00	07400 RENAL DIALYSIS	0	1,488,506	0.000000	0
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	747,908	0.000000	0
90.00	09000 CLINIC	0	105,117	0.000000	0
91.00	09100 EMERGENCY	100,340	33,387,872	0.003005	165,124
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	19,142,056	0.000000	0
200.00	Total (Lines 50-199)	869,124	580,950,027		1,161,545

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015
Component CCN: 14S015

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center-Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
Title XVIII		11.00	12.00	13.00	21.00	22.00	
Subprovider - IPF							
PPS							
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	217	0	0	0	0	54.00
60.00	06000 LABORATORY	770	0	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	9	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	496	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	1,492	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN:140015 Component CCN:14S015	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/28/2014 2:15 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part II
Date/Time Prepared:
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Component CCN: 14T015

Title XVIII

Subprovider -
IRF

PPS

Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,426,055	72,321,328	0.047373	27,930	1,323	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	133,749	5,531,732	0.024179	0	0	52.00
53.00	05300 ANESTHESIOLOGY	220,315	15,181,010	0.014513	2,344	34	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,984,622	104,644,491	0.028522	284,597	8,117	54.00
60.00	06000 LABORATORY	728,175	75,297,482	0.009671	656,774	6,352	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	35,533	3,888,688	0.009138	26,163	239	62.00
65.00	06500 RESPIRATORY THERAPY	178,743	10,878,984	0.016430	181,863	2,988	65.00
66.00	06600 PHYSICAL THERAPY	121,940	3,967,556	0.030734	1,039,311	31,942	66.00
67.00	06700 OCCUPATIONAL THERAPY	29,865	2,338,261	0.012772	764,088	9,759	67.00
68.00	06800 SPEECH PATHOLOGY	13,862	1,328,175	0.010437	317,107	3,310	68.00
69.00	06900 ELECTROCARDIOLOGY	913,909	59,140,736	0.015453	47,755	738	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	75,544	2,027,102	0.037267	2,230	83	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	326,713	46,625,458	0.007007	87,589	614	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	492,172	34,160,833	0.014407	18,802	271	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	683,264	88,746,732	0.007699	820,261	6,315	73.00
74.00	07400 RENAL DIALYSIS	15,345	1,488,506	0.010309	30,064	310	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	59,387	747,908	0.079404	0	0	88.00
90.00	09000 CLINIC	45,717	105,117	0.434915	0	0	90.00
91.00	09100 EMERGENCY	599,031	33,387,872	0.017942	9,333	167	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	19,142,056	0.000000	0	0	92.00
200.00	Total (lines 50-199)	11,083,941	580,950,027		4,316,211	72,562	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015
Component CCN: 14T015

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	152,494	0	0	152,494	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	186,990	0	0	186,990	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	300,406	0	300,406	54.00
60.00	06000 LABORATORY	0	0	120,681	0	120,681	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	8,213	0	0	8,213	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	100,340	0	0	100,340	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	448,037	421,087	0	869,124	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/28/2014 2:15 pm	
		Component CCN: 14T015	Title XVIII	Subprovider - IRF	PPS
Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)	Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges
	6.00	7.00	8.00	9.00	10.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	152,494	72,321,328	0.002109	27,930
52.00	05200 DELIVERY ROOM & LABOR ROOM	186,990	5,531,732	0.033803	0
53.00	05300 ANESTHESIOLOGY	0	15,181,010	0.000000	2,344
54.00	05400 RADIOLOGY-DIAGNOSTIC	300,406	104,644,491	0.002871	284,597
60.00	06000 LABORATORY	120,681	75,297,482	0.001603	656,774
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	3,888,688	0.000000	26,163
65.00	06500 RESPIRATORY THERAPY	0	10,878,984	0.000000	181,863
66.00	06600 PHYSICAL THERAPY	0	3,967,556	0.000000	1,039,311
67.00	06700 OCCUPATIONAL THERAPY	0	2,338,261	0.000000	764,088
68.00	06800 SPEECH PATHOLOGY	0	1,328,175	0.000000	317,107
69.00	06900 ELECTROCARDIOLOGY	8,213	59,140,736	0.000139	47,755
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,027,102	0.000000	2,230
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	46,625,458	0.000000	87,589
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	34,160,833	0.000000	18,802
73.00	07300 DRUGS CHARGED TO PATIENTS	0	88,746,732	0.000000	820,261
74.00	07400 RENAL DIALYSIS	0	1,488,506	0.000000	30,064
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	747,908	0.000000	0
90.00	09000 CLINIC	0	105,117	0.000000	0
91.00	09100 EMERGENCY	100,340	33,387,872	0.003005	9,333
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	19,142,056	0.000000	0
200.00	Total (lines 50-199)	869,124	580,950,027		4,316,211

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015
Component CCN: 14T015

Period:
From 10/01/2012
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Worksheet D
Part IV
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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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
Title XVIII		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	59	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	817	0	0	0	0	54.00
60.00	06000 LABORATORY	1,053	0	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	7	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	28	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	1,964	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015
Component CCN: 14T015

Period:
From 10/01/2012
To 09/30/2013

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Part IV
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Title XVIII

Subprovider -
IRF

PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/28/2014 2:15 pm			
		Title XVIII	Skilled Nursing Facility	PPS			
Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	152,494	0	0	152,494	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	186,990	0	0	186,990	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	300,406	0	300,406	54.00
60.00	06000 LABORATORY	0	0	120,681	0	120,681	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	8,213	0	0	8,213	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	100,340	0	0	100,340	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	448,037	421,087	0	869,124	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015
Component CCN: 145643

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)	Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	152,494	72,321,328	0.002109	0.002109	20,356	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	186,990	5,531,732	0.033803	0.033803	0	52.00
53.00	05300 ANESTHESIOLOGY	0	15,181,010	0.000000	0.000000	676	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	300,406	104,644,491	0.002871	0.002871	164,793	54.00
60.00	06000 LABORATORY	120,681	75,297,482	0.001603	0.001603	934,308	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	3,888,688	0.000000	0.000000	86,379	62.00
65.00	06500 RESPIRATORY THERAPY	0	10,878,984	0.000000	0.000000	635,980	65.00
66.00	06600 PHYSICAL THERAPY	0	3,967,556	0.000000	0.000000	707,511	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,338,261	0.000000	0.000000	505,262	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,328,175	0.000000	0.000000	54,800	68.00
69.00	06900 ELECTROCARDIOLOGY	8,213	59,140,736	0.000139	0.000139	53,818	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,027,102	0.000000	0.000000	3,717	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	46,625,458	0.000000	0.000000	165,022	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	34,160,833	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	88,746,732	0.000000	0.000000	2,947,164	73.00
74.00	07400 RENAL DIALYSIS	0	1,488,506	0.000000	0.000000	58,181	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	747,908	0.000000	0.000000	0	88.00
90.00	09000 CLINIC	0	105,117	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	100,340	33,387,872	0.003005	0.003005	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	19,142,056	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	869,124	580,950,027			6,337,967	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015
Component CCN: 145643

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
Title XVIII			11.00	12.00	13.00	21.00	22.00	
Skilled Nursing Facility								
PPS								
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	43	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	473	0	0	0	0	54.00
60.00	06000	LABORATORY	1,498	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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
200.00		Total (lines 50-199)	2,021	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2012 To 09/30/2013	worksheet D Part IV Date/Time Prepared: 2/28/2014 2:15 pm
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS. (NON-DISTINCT PART)	0	0	92.00
200.00	Total (lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

worksheet D-1

Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			40,430 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			40,430 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			32,402 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			20,251 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			37,366,326 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			37,366,326 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation 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)			37,366,326 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)			924.22 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			18,716,379 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)			18,716,379 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet D-1

Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	PPS
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	7,550,118	3,951	1,910.94	2,625	5,016,218	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)					28,670,675	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					52,403,272	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					3,319,012	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,440,376	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					5,759,388	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					46,643,884	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)					8,028	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					924.22	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					7,419,638	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

worksheet D-1

Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description	Cost	Title XVIII		Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)			
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00 Capital-related cost	2,452,657	37,366,326	0.065638	7,419,638	487,010	90.00	
91.00 Nursing school cost	3,285,473	37,366,326	0.087926	7,419,638	652,379	91.00	
92.00 Allied health cost	0	37,366,326	0.000000	7,419,638	0	92.00	
93.00 All other Medical Education	0	37,366,326	0.000000	7,419,638	0	93.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015
Component CCN: 145015

Period:
From 10/01/2012
To 09/30/2013

Worksheet D-1

Date/Time Prepared:
2/28/2014 2:15 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description

1.00

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,068	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,068	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)	12,068	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,378	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00

SWING BED ADJUSTMENT

17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,076,086	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,076,086	27.00

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28.00	General inpatient routine service charges (excluding swing-bed and observation 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)	9,076,086	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)	752.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,788,446	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,788,446	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015
Component CCN: 14S015

Period:
From 10/01/2012
To 09/30/2013

Worksheet D-1
Date/Time Prepared:
2/28/2014 2:15 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,99,959	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,988,405	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)					152,311	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					15,489	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					167,800	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,820,605	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015
Component CCN: 14S015

Period:
From 10/01/2012
To 09/30/2013

Worksheet D-1
Date/Time Prepared:
2/28/2014 2:15 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	449,787	9,076,086	0.049557	0	0	90.00
91.00 Nursing School cost	323,195	9,076,086	0.035610	0	0	91.00
92.00 Allied health cost	0	9,076,086	0.000000	0	0	92.00
93.00 All other Medical Education	0	9,076,086	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2012 To 09/30/2013	worksheet D-1 Date/Time Prepared: 2/28/2014 2:15 pm
Cost Center Description		Title XVIII	Subprovider - IRF	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,912 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,912 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			4,912 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			3,596 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			4,368,163 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			4,368,163 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation 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)			4,368,163 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)			889.28 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,197,851 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)			3,197,851 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN:140015
Component CCN:14T015

Period:
From 10/01/2012
To 09/30/2013

Worksheet D-1
Date/Time Prepared:
2/28/2014 2:15 pm

Title XVIII

Subprovider -
IRF

PPS

Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,469,960	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,667,811	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)					218,241	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					74,526	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					292,767	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,375,044	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015

Period:

Worksheet D-1

Component CCN: 14T015

From 10/01/2012

Date/Time Prepared:

To 09/30/2013

2/28/2014 2:15 pm

Title XVIII

Subprovider -

PPS

Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	298,130	4,368,163	0.068251	0	0	90.00
91.00 Nursing School cost	0	4,368,163	0.000000	0	0	91.00
92.00 Allied health cost	0	4,368,163	0.000000	0	0	92.00
93.00 All other Medical Education	0	4,368,163	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1
Component CCN: 145643		Date/Time Prepared: 2/28/2014 2:15 pm
Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description		1.00
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PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,652	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,652	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,652	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,752	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00

SWING BED ADJUSTMENT

17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,003,834	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,003,834	27.00

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28.00	General inpatient routine service charges (excluding swing-bed and observation 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)	4,003,834	37.00

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS

38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015
Component CCN: 145643

Period:
From 10/01/2012
To 09/30/2013

Worksheet D-1
Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1.00	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					4,003,834	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					708.39	71.00
72.00	Program routine service cost (line 9 x line 71)					3,366,269	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					3,366,269	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					3,366,269	83.00
84.00	Program inpatient ancillary services (see instructions)					1,696,742	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					5,063,011	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015
Component CCN: 145643

Period:
From 10/01/2012
To 09/30/2013

Worksheet D-1
Date/Time Prepared:
2/28/2014 2:15 pm
PPS

Title XVIII

Skilled Nursing Facility

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet D-3

Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		Title XVIII	Hospital	PPS
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		34,497,945	30.00
31.00	03100 INTENSIVE CARE UNIT		15,343,861	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		0	41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.305602	12,434,149	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.533100	14,635	52.00
53.00	05300 ANESTHESIOLOGY	0.058505	3,293,883	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135695	15,348,404	54.00
60.00	06000 LABORATORY	0.119773	16,855,210	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.409110	1,731,478	62.00
65.00	06500 RESPIRATORY THERAPY	0.325327	6,597,745	65.00
66.00	06600 PHYSICAL THERAPY	0.650258	1,010,225	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.384561	447,517	67.00
68.00	06800 SPEECH PATHOLOGY	0.307082	285,927	68.00
69.00	06900 ELECTROCARDIOLOGY	0.073529	16,067,159	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.265603	117,947	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.199910	11,683,131	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.396491	12,858,441	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.195813	29,936,134	73.00
74.00	07400 RENAL DIALYSIS	0.487337	854,211	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000 CLINIC	2.471779	440	90.00
91.00	09100 EMERGENCY	0.296160	4,412,541	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.387609	1,456,430	92.00
200.00	Total (sum of lines 50-94 and 96-98)		135,405,607	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)		135,405,607	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140015 Component CCN: 14S015	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/28/2014 2:15 pm
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		4,254,086	40.00
41.00	04100 SUBPROVIDER - IRF		0	41.00
43.00	04300 NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.305602	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.533100	0	52.00
53.00	05300 ANESTHESIOLOGY	0.058505	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135695	75,687	54.00
60.00	06000 LABORATORY	0.119773	480,442	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.409110	643	62.00
65.00	06500 RESPIRATORY THERAPY	0.325327	21,030	65.00
66.00	06600 PHYSICAL THERAPY	0.650258	3,394	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.384561	650	67.00
68.00	06800 SPEECH PATHOLOGY	0.307082	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.073529	63,289	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.265603	2,973	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.199910	7,718	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.396491	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.195813	340,595	73.00
74.00	07400 RENAL DIALYSIS	0.487337	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000 CLINIC	2.471779	0	90.00
91.00	09100 EMERGENCY	0.296160	165,124	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.387609	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,161,545	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		1,161,545	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/28/2014 2:15 pm
Cost Center Description		Title XVIII	Subprovider - IRF	PPS
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		3,657,045	41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.305602	27,930	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.533100	0	52.00
53.00	05300 ANESTHESIOLOGY	0.058505	2,344	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135695	284,597	54.00
60.00	06000 LABORATORY	0.119773	656,774	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.409110	26,163	62.00
65.00	06500 RESPIRATORY THERAPY	0.325327	181,863	65.00
66.00	06600 PHYSICAL THERAPY	0.650258	1,039,311	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.384561	764,088	67.00
68.00	06800 SPEECH PATHOLOGY	0.307082	317,107	68.00
69.00	06900 ELECTROCARDIOLOGY	0.073529	47,755	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.265603	2,230	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.199910	87,589	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.396491	18,802	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.195813	820,261	73.00
74.00	07400 RENAL DIALYSIS	0.487337	30,064	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000 CLINIC	2.471779	0	90.00
91.00	09100 EMERGENCY	0.296160	9,333	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.387609	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,316,211	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		4,316,211	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/28/2014 2:15 pm
Cost Center Description		Title XVIII	Skilled Nursing Facility	PPS
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (Col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		0	41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.304742	20,356	6,203
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.533100	0	0
53.00	05300 ANESTHESIOLOGY	0.058505	676	40
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135695	164,793	22,362
60.00	06000 LABORATORY	0.119773	934,308	111,905
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.409110	86,379	35,339
65.00	06500 RESPIRATORY THERAPY	0.324440	635,980	206,337
66.00	06600 PHYSICAL THERAPY	0.650258	707,511	460,065
67.00	06700 OCCUPATIONAL THERAPY	0.384561	505,262	194,304
68.00	06800 SPEECH PATHOLOGY	0.307082	54,800	16,828
69.00	06900 ELECTROCARDIOLOGY	0.073333	53,818	3,947
70.00	07000 ELECTROENCEPHALOGRAPHY	0.262229	3,717	975
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.199910	165,022	32,990
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.396491	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.195813	2,947,164	577,093
74.00	07400 RENAL DIALYSIS	0.487337	58,181	28,354
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		0
90.00	09000 CLINIC	2.459402	0	0
91.00	09100 EMERGENCY	0.290391	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.387609	0	0
200.00	Total (sum of lines 50-94 and 96-98)		6,337,967	1,696,742
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0
202.00	Net Charges (line 200 minus line 201)		6,337,967	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet E
Part A
Date/Time Prepared:
2/28/2014 2:15 pm

		Title XVIII	Hospital	PPS
		0	before 1/1	on/after 1/1
			1.00	1.01
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		37,704,921	1.00
2.00	Outlier payments for discharges. (see instructions)		1,431,845	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		1,624,494	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		167.01	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		19.50	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		19.50	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		17.01	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)		17.01	12.00
13.00	Total allowable FTE count for the prior year.		16.71	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.		14.45	14.00
15.00	Sum of lines 12 through 14 divided by 3.		16.06	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		16.06	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.096162	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.088274	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.088274	21.00
22.00	IME payment adjustment (see instructions)		1,850,567	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)		1,850,567	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.29	30.00
31.00	Percentage of Medicaid patient days (see instructions)		13.92	31.00
32.00	Sum of lines 30 and 31		18.21	32.00
33.00	Allowable disproportionate share percentage (see instructions)		4.59	33.00
34.00	Disproportionate share adjustment (see instructions)		1,730,656	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	0 41.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet E
Part A
Date/Time Prepared:
2/28/2014 2:15 pm

		Title XVIII	Hospital	PPS	
		0	before 1/1	on/after 1/1	
			1.00	1.01	
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	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)		42,717,989		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		45,449,963		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		45,449,963		49.00
50.00	Payment for inpatient program capital (from worksheet L, Parts I, II, as applicable)		3,239,179		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).		567,182		52.00
53.00	Nursing and Allied Health Managed Care payment		49,468		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of teaching physicians (worksheet D-5, Part II, col. 3, line 20)		0		56.00
57.00	Routine service other pass through costs (from wkst D, Part III, column 9, lines 30-35).		1,739,807		57.00
58.00	Ancillary service other pass through costs worksheet D, Part IV, col. 11 line 200)		162,933		58.00
59.00	Total (sum of amounts on lines 49 through 58)		51,208,532		59.00
60.00	Primary payer payments		25,605		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		51,182,927		61.00
62.00	Deductibles billed to program beneficiaries		4,266,556		62.00
63.00	Coinsurance billed to program beneficiaries		93,882		63.00
64.00	Allowable bad debts (see instructions)		761,470		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		494,956		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		761,470		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		47,317,445		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
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		-36,077		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-33,933		70.94
70.95	Recovery of Accelerated Depreciation		0		70.95
70.96	Low Volume Payment-1 (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume Payment-2 (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	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)		47,247,435		71.00
71.01	Sequestration adjustment (see instructions)		472,474		71.01
72.00	Interim payments		46,949,866		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		-174,905		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0		75.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet E
Part A
Date/Time Prepared:
2/28/2014 2:15 pm

		Title XVIII	Hospital	PPS	
				before 1/1	on/after 1/1
		0		1.00	1.01
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 DSH PAYMENT PERCENTAGE

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet DSH

Date/Time Prepared:
2/28/2014 2:15 pm

		Title XVIII		Hospital		PPS	
		Original Values	Adjusted Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	4.29	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	13.92	0.00			13.92	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	18.21	0.00			13.92	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	RRC				RRC	4.00
5.00	Bed days available divided by number of days in the cost reporting period (worksheet E, Part A, Line 4)	167.01	0.00			167.01	5.00
6.00	Disproportionate Share Payment Percentage (transfer to worksheet E, Part A, line 33)	4.59	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				No	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	1.97	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (worksheet S-2, line 24, column 1)	4,655	0			4,655	15.00
16.00	In-State Medicaid eligible unpaid paid days (worksheet S-2, line 24, column 2)	0	0			0	16.00
17.00	Out-of-State Medicaid paid days (worksheet S-2, line 24, column 3)	591	0			591	17.00
18.00	Out-of-State Medicaid eligible unpaid days (worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (worksheet S-2, line 24, column 5)	264	0			264	19.00
20.00	Other Medicaid days (worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	5,510	0			5,510	21.00
22.00	Total patient days (worksheet S-3, Part I, Column 8, Line 14)	38,763	0			38,763	22.00
23.00	Plus total labor room days (worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (worksheet S-3, Part I, Column 8, Line 30)	821	0			821	24.00
25.00	Less total swing-bed SNF and NF patient days (worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	39,584	0			39,584	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by Line 26)	13.92	0.00			13.92	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet DSH

Date/Time Prepared:
2/28/2014 2:15 pm

		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	False	0.00		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	True	4.59		0.00	True	29.00
30.00	Line 28 or 29 as applicable		4.59		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		0.00		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	True				True	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	True				True	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet DSH

Date/Time Prepared:
2/28/2014 2:15 pm

Title XVIII

Hospital

PPS

		Revised Percentage	
		6.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	3.20	29.00
30.00	Line 28 or 29 as applicable	3.20	30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00	31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet E
Part B
Date/Time Prepared:
2/28/2014 2:15 pm

		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		70	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		23,540,698	2.00
3.00	PPS payments		21,413,498	3.00
4.00	Outlier payment (see instructions)		178,200	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.897	5.00
6.00	Line 2 times line 5		21,116,006	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		427,883	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		70	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		582	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)		582	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		582	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		512	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)		70	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)		22,019,581	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)		4,918,603	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)		17,101,048	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)		213,241	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)		17,314,289	30.00
31.00	Primary payer payments		3,190	31.00
32.00	Subtotal (line 30 minus line 31)		17,311,099	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)		719,877	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		467,920	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		719,877	36.00
37.00	Subtotal (see instructions)		17,779,019	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-203	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		17,779,222	40.00
40.01	Sequestration adjustment (see instructions)		177,792	40.01
41.00	Interim payments		17,759,227	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-157,797	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
			Overrides	
			1.00	
WORKSHEET OVERRIDE VALUES				
112.00	override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet E-1
Part I
Date/Time Prepared:
2/28/2014 2:15 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		48,210,436		17,623,334	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	04/18/2013	135,893	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	04/18/2013	478,671		0	3.50
3.51		09/26/2013	781,899		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)		-1,260,570		135,893	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)		46,949,866		17,759,227	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		174,905		157,797	6.02
7.00	Total Medicare program liability (see instructions)		46,774,961		17,601,430	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140015
Component CCN: 14S015

Period:
From 10/01/2012
To 09/30/2013

Worksheet E-1
Part I
Date/Time Prepared:
2/28/2014 2:15 pm

		Title XVIII		Subprovider - IPF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,637,443		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		1,637,443		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		159,452		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,796,895		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor	0				8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2012 To 09/30/2013	Worksheet E-1 Part I Date/Time Prepared: 2/28/2014 2:15 pm	
		Title XVIII	Subprovider - IRF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		5,144,467		0
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	04/18/2013	34,837		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-34,837		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,109,630		0
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
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		28,652		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		5,138,282		0
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 140015 Component CCN: 145643		Period: From 10/01/2012 To 09/30/2013		Worksheet E-1 Part I Date/Time Prepared: 2/28/2014 2:15 pm	
		Title XVIII		Skilled Nursing Facility		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,611,539		0		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,611,539		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		159,055		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		1,770,594		0		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	Worksheet E-1 Part II Date/Time Prepared: 2/28/2014 2:15 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14		9,708	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12		22,876	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2		753	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12		36,353	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200		703,272,052	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20		63,003,882	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology worksheet S-2, Part I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		1,325,113	8.00
9.00	Sequestration adjustment amount (see instructions)		26,502	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		1,298,611	10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		0	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		1,298,611	32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment		0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part II Date/Time Prepared: 2/28/2014 2:15 pm
Component CCN: 14S015	Title XVIII	Subprovider - IPF
		PPS

		1.00	
PART II - MEDICARE PART A SERVICES - IPF PPS			
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,943,355	1.00
2.00	Net IPF PPS Outlier Payments	2,249	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	33.063014	9.00
10.00	Indirect Medical Education Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.	0.000000	10.00
11.00	Indirect Medical Education Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,945,604	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)	0	14.00
15.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,945,604	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,945,604	18.00
19.00	Deductibles	267,368	19.00
20.00	Subtotal (line 18 minus line 19)	1,678,236	20.00
21.00	Coinsurance	21,016	21.00
22.00	Subtotal (line 20 minus line 21)	1,657,220	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	142,539	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	92,650	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	142,539	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,749,870	26.00
27.00	Direct graduate medical education payments (from worksheet E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	65,175	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,815,045	31.00
31.01	Sequestration adjustment (see instructions)	18,150	31.01
32.00	Interim payments	1,637,443	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33	159,452	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	35.00
TO BE COMPLETED BY CONTRACTOR			
50.00	Original outlier amount from worksheet E-3, Part II, line 2	2,249	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part III Date/Time Prepared: 2/28/2014 2:15 pm
		Component CCN: 14T015	Title XVIII	Subprovider - IRF
				PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		5,007,190	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0197	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		202,791	3.00
4.00	Outlier Payments		40,479	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	5.01
6.00	New teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)		0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		13.457534	10.00
11.00	Indirect Medical Education Adjustment Factor $\{(1 + (\text{line 9}/\text{line 10})) \text{ raised to the power of } .6876 - 1\}$.		0.000000	11.00
12.00	Indirect Medical Education Adjustment (line 1 multiplied by line 11).		0	12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)		5,250,460	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		0	15.00
16.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)		0	16.00
17.00	Subtotal (see instructions)		5,250,460	17.00
18.00	Primary payer payments		2,311	18.00
19.00	Subtotal (line 17 less line 18).		5,248,149	19.00
20.00	Deductibles		38,820	20.00
21.00	Subtotal (line 19 minus line 20)		5,209,329	21.00
22.00	Coinsurance		21,109	22.00
23.00	Subtotal (line 21 minus line 22)		5,188,220	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	26.00
27.00	Subtotal (sum of lines 23 and 25)		5,188,220	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 49)		0	28.00
29.00	Other pass through costs (see instructions)		1,964	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00
31.99	Recovery of Accelerated Depreciation		0	31.99
32.00	Total amount payable to the provider (see instructions)		5,190,184	32.00
32.01	Sequestration adjustment (see instructions)		51,902	32.01
33.00	Interim payments		5,109,630	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34		28,652	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from worksheet E-3, Part III, line 4		40,479	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part VI Date/Time Prepared: 2/28/2014 2:15 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		1,718,536	1.00
2.00	Routine service other pass through costs		157,196	2.00
3.00	Ancillary service other pass through costs		2,021	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,877,753	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		90,178	7.00
8.00	Allowable bad debts (see instructions)		1,027	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		1,027	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		904	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)		1,788,479	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)		1,788,479	15.00
15.01	Sequestration adjustment (see instructions)		17,885	15.01
16.00	Interim payments		1,611,539	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17		159,055	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2		0	19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	Worksheet E-4 Date/Time Prepared: 2/28/2014 2:15 pm
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	Title XVIII	Hospital	PPS
			1.00

COMPUTATION OF TOTAL DIRECT GME AMOUNT			
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.		19.50 1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)		0.00 2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA		0.00 3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)		0.00 3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))		0.00 4.00
4.01	ACA Section 5503 increase to the Direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)		0.00 4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)		0.00 4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)		19.50 5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)		18.09 6.00
7.00	Enter the lesser of line 5 or line 6		18.09 7.00
		Primary Care 1.00	Other 2.00
			Total 3.00
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	18.09	0.00 18.09 8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	18.09	0.00 18.09 9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00 10.00
11.00	Total weighted FTE count	18.09	0.00 11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	16.71	0.00 12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	18.26	0.00 13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	17.69	0.00 14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00 15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00 16.00
17.00	Adjusted rolling average FTE count	17.69	0.00 17.00
18.00	Per resident amount	79,767.53	0.00 18.00
19.00	Approved amount for resident costs	1,411,088	0 1,411,088 19.00

COMPUTATION OF ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS			
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)		0.00 20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)		0.00 21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)		0.00 22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)		0.00 23.00
24.00	Multiply line 22 time line 23		0 24.00
25.00	Total direct GME amount (sum of lines 19 and 24)		1,411,088 25.00

COMPUTATION OF PROGRAM PATIENT LOAD			
		Inpatient Part A 1.00	Managed care 2.00 3.00

26.00	Inpatient Days	28,850	753	26.00
27.00	Total Inpatient Days (see instructions)	53,333	53,333	27.00
28.00	Ratio of inpatient days to total inpatient days	0.540941	0.014119	28.00
29.00	Program direct GME amount	763,315	19,923	29.00
30.00	Reduction for direct GME payments for Medicare managed care		2,815	30.00
31.00	Net Program direct GME amount		780,423	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	Worksheet E-4 Date/Time Prepared: 2/28/2014 2:15 pm
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	Title XVIII	Hospital	PPS	
			1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Worksheet C, Part I, column 8, sum of lines 74 and 94)		1,488,506	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		64,303,510	37.00
38.00	Organ acquisition costs (Worksheet D-4, Part III, column 1, line 69)		0	38.00
39.00	Cost of teaching physicians (Worksheet D-5, Part II, column 3, line 20)		0	39.00
40.00	Primary payer payments (see instructions)		27,916	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		64,275,594	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		24,170,777	42.00
43.00	Primary payer payments (see instructions)		5,292	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		24,165,485	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		88,441,079	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.726762	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.273238	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		780,423	48.00
49.00	Part A Medicare GME payment (line 46 x 48)(Title XVIII only)(see instructions)		567,182	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		213,241	50.00

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

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

worksheet G

Date/Time Prepared:
2/28/2014 2:15 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	75,644,457	0	0	0	1.00
2.00 Temporary investments	85,025,871	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	131,232,605	0	0	0	4.00
5.00 Other receivable	7,607,215	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-79,115,288	0	0	0	6.00
7.00 Inventory	5,947,158	0	0	0	7.00
8.00 Prepaid expenses	5,189,318	0	0	0	8.00
9.00 Other current assets	155,106	0	0	0	9.00
10.00 Due from other funds	6,153,971	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	237,840,413	0	0	0	11.00
FIXED ASSETS					
12.00 Land	12,869,734	0	0	0	12.00
13.00 Land improvements	6,558,946	0	0	0	13.00
14.00 Accumulated depreciation	-4,640,555	0	0	0	14.00
15.00 Buildings	161,417,937	0	0	0	15.00
16.00 Accumulated depreciation	-60,198,232	0	0	0	16.00
17.00 Leasehold improvements	4,415,584	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	-29,920,488	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	150,390,480	0	0	0	23.00
24.00 Accumulated depreciation	-109,541,458	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)	131,351,948	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	14,743,744	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	9,896,787	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	24,640,531	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	393,832,892	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	18,681,671	0	0	0	37.00
38.00 Salaries, wages, and fees payable	16,903,776	0	0	0	38.00
39.00 Payroll taxes payable	582,377	0	0	0	39.00
40.00 Notes and loans payable (short term)	3,610,508	0	0	0	40.00
41.00 Deferred income	1,224,183	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	8,981,021	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	49,983,536	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	73,644,991	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	57,500,073	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	131,145,064	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	181,128,600	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	212,704,292	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	212,704,292	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	393,832,892	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

worksheet G-1

Date/Time Prepared:
2/28/2014 2:15 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		148,624,681			0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		31,508,840				2.00
3.00	Total (sum of line 1 and line 2)		180,133,521			0	3.00
4.00	PENSION LIABILITY ADJUSTMENT	33,736,516					4.00
5.00	CONTRIBUTIONS	6,575,801					5.00
6.00		0					6.00
7.00		0					7.00
8.00		0					8.00
9.00		0					9.00
10.00	Total additions (sum of line 4-9)		40,312,317			0	10.00
11.00	Subtotal (line 3 plus line 10)		220,445,838			0	11.00
12.00	NET ASSETS RELEASED	7,696,308					12.00
13.00	OTHER	45,238					13.00
14.00		0					14.00
15.00		0					15.00
16.00		0					16.00
17.00		0					17.00
18.00	Total deductions (sum of lines 12-17)		7,741,546			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		212,704,292			0	19.00
		Endowment Fund		Plant Fund			
		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	PENSION LIABILITY ADJUSTMENT		0				4.00
5.00	CONTRIBUTIONS		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			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	NET ASSETS RELEASED		0				12.00
13.00	OTHER		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	55,090,257		55,090,257	1.00
2.00	SUBPROVIDER - IPF	22,080,369		22,080,369	2.00
3.00	SUBPROVIDER - IRF	5,210,173		5,210,173	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	4,632,873		4,632,873	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)	87,013,672		87,013,672	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	24,905,859		24,905,859	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)	24,905,859		24,905,859	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	111,919,531		111,919,531	17.00
18.00	Ancillary services	273,492,971	376,880,063	650,373,034	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	747,908	747,908	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		7,389,726	7,389,726	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	4,563	4,096,345	4,100,908	26.00
27.00	NURSERY	3,003,183	0	3,003,183	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	388,420,248	389,114,042	777,534,290	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		277,426,816		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)		277,426,816		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet G-3

Date/Time Prepared:
2/28/2014 2:15 pm

		1:00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	777,534,290	1.00
2.00	Less contractual allowances and discounts on patients' accounts	497,394,668	2.00
3.00	Net patient revenues (line 1 minus line 2)	280,139,622	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	277,426,816	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,712,806	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	7,340,166	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	378,659	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,479,741	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	33,194	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	3,126,291	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	895,305	22.00
23.00	Governmental appropriations	0	23.00
24.00	TRANSFERS	2,821,808	24.00
24.01	TRANSFERS	335,289	24.01
24.02	MISCELLANEOUS INCOME	12,376,398	24.02
24.03	OTHER	9,183	24.03
25.00	Total other income (sum of lines 6-24)	28,796,034	25.00
26.00	Total (line 5 plus line 25)	31,508,840	26.00
27.00		0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	31,508,840	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet H

HHA CCN: 147031

Date/Time Prepared:
2/28/2014 2:15 pm

		Salaries	Employee Benefits	Transportation (see Instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	452,070	0	0	86	0	452,156	5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	1,647,425	0	10,763	0	712,293	2,370,481	6.00
7.00	Physical Therapy	917,912	0	4,140	0	273,969	1,196,021	7.00
8.00	Occupational Therapy	314,901	0	1,635	0	108,200	424,736	8.00
9.00	Speech Pathology	43,084	0	256	0	16,962	60,302	9.00
10.00	Medical Social Services	174,628	0	37	0	2,442	177,107	10.00
11.00	Home Health Aide	279,037	0	2,586	0	171,166	452,789	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	10,882	0	0	0	125,536	136,418	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	3,839,939	0	19,417	86	1,410,568	5,270,010	24.00
		Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	0	452,156	0	452,156	0	0	5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	-1,683	2,368,798	0	2,368,798	0	0	6.00
7.00	Physical Therapy	0	1,196,021	0	1,196,021	0	0	7.00
8.00	Occupational Therapy	0	424,736	0	424,736	0	0	8.00
9.00	Speech Pathology	0	60,302	0	60,302	0	0	9.00
10.00	Medical Social Services	0	177,107	0	177,107	0	0	10.00
11.00	Home Health Aide	0	452,789	0	452,789	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	136,418	0	136,418	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	-1,683	5,268,327	0	5,268,327	0	0	24.00

column, 6 line 24 should agree with the worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 140015

Period: From 10/01/2012

Worksheet H-1

HHA CCN: 147031

To 09/30/2013

Part I

Date/Time Prepared: 2/28/2014 2:15 pm

Home Health Agency I

PPS

	Net Expenses for Cost Allocation (From Wkst. H, col. 10)	Capital Related Costs				Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance				
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	452,156	0	0	0	0	452,156	5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	2,368,798	0	0	0	0	2,368,798	6.00
7.00	Physical Therapy	1,196,021	0	0	0	0	1,196,021	7.00
8.00	Occupational Therapy	424,736	0	0	0	0	424,736	8.00
9.00	Speech Pathology	60,302	0	0	0	0	60,302	9.00
10.00	Medical Social Services	177,107	0	0	0	0	177,107	10.00
11.00	Home Health Aide	452,789	0	0	0	0	452,789	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	136,418	0	0	0	0	136,418	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	5,268,327	0	0	0	0	5,268,327	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	452,156						5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	222,391	2,591,189					6.00
7.00	Physical Therapy	112,286	1,308,307					7.00
8.00	Occupational Therapy	39,875	464,611					8.00
9.00	Speech Pathology	5,661	65,963					9.00
10.00	Medical Social Services	16,627	193,734					10.00
11.00	Home Health Aide	42,509	495,298					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	12,807	149,225					22.00
23.00	All Others (specify)	0	0					23.00
24.00	Total (sum of lines 1-23)		5,268,327					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 140015

Period:

Worksheet H-1

HHA CCN: 147031

From 10/01/2012

Part II

To 09/30/2013

Date/Time Prepared:

2/28/2014 2:15 pm

Home Health Agency I

PPS

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
1.00	2.00	3.00	4.00					
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0	0		4.00
5.00	Administrative and General	0	0	0		-452,156	4,816,171	5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	0	0	0	0	2,368,798	6.00
7.00	Physical Therapy	0	0	0	0	0	1,196,021	7.00
8.00	Occupational Therapy	0	0	0	0	0	424,736	8.00
9.00	Speech Pathology	0	0	0	0	0	60,302	9.00
10.00	Medical Social Services	0	0	0	0	0	177,107	10.00
11.00	Home Health Aide	0	0	0	0	0	452,789	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	136,418	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-452,156	4,816,171	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	0	452,156	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.093883	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140015

Period: From 10/01/2012

Worksheet H-2

HHA CCN: 147031

To 09/30/2013

Part I

Date/Time Prepared: 2/28/2014 2:15 pm

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS				14TH STREET	
		BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT		
	0	1.00	1.01	1.02	1.03	1.04	
1.00 Administrative and General	0	0	0	0	0	5,274	1.00
2.00 Skilled Nursing Care	2,591,189	0	0	0	0	0	2.00
3.00 Physical Therapy	1,308,307	0	0	0	0	0	3.00
4.00 Occupational Therapy	464,611	0	0	0	0	0	4.00
5.00 Speech Pathology	65,963	0	0	0	0	0	5.00
6.00 Medical Social Services	193,734	0	0	0	0	0	6.00
7.00 Home Health Aide	495,298	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	149,225	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	5,268,327	0	0	0	0	5,274	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

Cost Center Description	CAPITAL RELATED COSTS				subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	
	MOB PHASE I	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT					
	1.05	2.00	4.00	4A	5.00	6.00		
1.00 Administrative and General	0	17,223	107,363	129,860	34,081	83,671	1.00	
2.00 Skilled Nursing Care	0	0	391,248	2,982,437	782,728	0	2.00	
3.00 Physical Therapy	0	0	217,996	1,526,303	400,572	0	3.00	
4.00 Occupational Therapy	0	0	74,786	539,397	141,563	0	4.00	
5.00 Speech Pathology	0	0	10,232	76,195	19,997	0	5.00	
6.00 Medical Social Services	0	0	41,473	235,207	61,729	0	6.00	
7.00 Home Health Aide	0	0	66,269	561,567	147,381	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	2,584	151,809	39,842	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19) (2)	0	17,223	911,951	6,202,775	1,627,893	83,671	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00	

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet H-2
Part I
Date/Time Prepared:
2/28/2014 2:15 pm

HHA CCN: 147031

Home Health
Agency I

PPS

Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
	8.00	9.00	10.00	11.00	13.00	16.00	
1.00 Administrative and General	0	130,437	0	156,377	750,558	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	0	130,437	0	156,377	750,558	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet H-2
Part I
Date/Time Prepared:
2/28/2014 2:15 pm

HHA CCN: 147031

Home Health
Agency I

PPS

Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
	24.00	25.00	26.00	27.00	28.00		
1.00 Administrative and General	1,284,984	0	1,284,984				1.00
2.00 Skilled Nursing Care	3,765,165	0	3,765,165	631,063	4,396,228		2.00
3.00 Physical Therapy	1,926,875	0	1,926,875	322,954	2,249,829		3.00
4.00 Occupational Therapy	680,960	0	680,960	114,132	795,092		4.00
5.00 Speech Pathology	96,192	0	96,192	16,122	112,314		5.00
6.00 Medical Social Services	296,936	0	296,936	49,768	346,704		6.00
7.00 Home Health Aide	708,948	0	708,948	118,823	827,771		7.00
8.00 Supplies (see instructions)	0	0	0	0	0		8.00
9.00 Drugs	0	0	0	0	0		9.00
10.00 DME	0	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0	0		13.00
14.00 Clinic	0	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0	0		17.00
18.00 Homemaker Service	191,651	0	191,651	32,122	223,773		18.00
19.00 All Others (specify)	0	0	0	0	0		19.00
20.00 Total (sum of lines 1-19) (2)	8,951,711	0	8,951,711	1,284,984	8,951,711		20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.167605			21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140015

Period: From 10/01/2012

worksheet H-2

HHA CCN: 147031

To 09/30/2013

Part II

Date/Time Prepared: 2/28/2014 2:15 pm

Home Health Agency I

PPS

Cost Center Description	CAPITAL RELATED COSTS						MOB PHASE I (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BUILDING FIXT (SQUARE FEET)	NEW BUILDING & FIXT (SQUARE FEET)	14TH STREET (SQUARE FEET)			
	1.00	1.01	1.02	1.03	1.04	1.05		
1.00 Administrative and General	0	0	0	0	4,925	0	1.00	
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00 Physical Therapy	0	0	0	0	0	0	3.00	
4.00 Occupational Therapy	0	0	0	0	0	0	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	0	0	0	0	0	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19)	0	0	0	0	4,925	0	20.00	
21.00 Total cost to be allocated	0	0	0	0	5,274	0	21.00	
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	1.070863	0.000000	22.00	

Cost Center Description	CAPITAL RELATED COSTS						LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)			
	2.00	4.00	5A	5.00	6.00	8.00		
1.00 Administrative and General	17,252	452,070	0	129,860	4,925	0	1.00	
2.00 Skilled Nursing Care	0	1,647,425	0	2,982,437	0	0	2.00	
3.00 Physical Therapy	0	917,912	0	1,526,303	0	0	3.00	
4.00 Occupational Therapy	0	314,901	0	539,397	0	0	4.00	
5.00 Speech Pathology	0	43,084	0	76,195	0	0	5.00	
6.00 Medical Social Services	0	174,628	0	235,207	0	0	6.00	
7.00 Home Health Aide	0	279,037	0	561,567	0	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	10,882	0	151,809	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19)	17,252	3,839,939	0	6,202,775	4,925	0	20.00	
21.00 Total cost to be allocated	17,223	911,951	0	1,627,893	83,671	0	21.00	
22.00 Unit cost multiplier	0.998319	0.237491	0	0.262446	16.989036	0.000000	22.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2012
To 09/30/2013

Worksheet H-2
Part II
Date/Time Prepared:
2/28/2014 2:15 pm

Home Health
Agency I

PPS

Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING	MEDICAL	NURSING SCHOOL	
	(HOURS OF SERVICE)	(MEALS SERVED)	(MEALS SERVED)	ADMINISTRATION (DIRECT NURS. HRS.)	RECORDS & LIBRARY (TIME SPENT)	(ASSIGNED TIME)	
	9.00	10.00	11.00	13.00	16.00	20.00	
1.00 Administrative and General	3,683	0	17,244	114,447	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	3,683	0	17,244	114,447	0	0	20.00
21.00 Total cost to be allocated	130,437	0	156,377	750,558	0	0	21.00
22.00 Unit cost multiplier	35.415965	0.000000	9.068488	6.558127	0.000000	0.000000	22.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140015

Period: From 10/01/2012

Worksheet H-3

HHA CCN: 147031

To 09/30/2013

Part I
Date/Time Prepared:
2/28/2014 2:15 pm

Title XVIII					Home Health Agency I	PPS
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 + col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION
Cost Per Visit Computation

1.00	Skilled Nursing Care	2.00	4,396,228		4,396,228	32,310	136.06	1.00
2.00	Physical Therapy	3.00	2,249,829	0	2,249,829	12,428	181.03	2.00
3.00	Occupational Therapy	4.00	795,092	0	795,092	4,910	161.93	3.00
4.00	Speech Pathology	5.00	112,314	0	112,314	771	145.67	4.00
5.00	Medical Social Services	6.00	346,704		346,704	113	3,068.18	5.00
6.00	Home Health Aide	7.00	827,771		827,771	7,762	106.64	6.00
7.00	Total (sum of lines 1-6)		8,727,938	0	8,727,938	58,294		7.00

Cost Center Description	Cost Limits	CBSA No. (I)	Program Visits		Ratio (col. 3 + col. 4)	
			Part A	Part B Not Subject to Deductibles & Coinsurance		
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation

8.00	Skilled Nursing Care	99914	10,510	11,857		8.00
8.01	Skilled Nursing Care	99926	970	843		8.01
9.00	Physical Therapy	99914	4,709	4,445		9.00
9.01	Physical Therapy	99926	399	175		9.01
10.00	Occupational Therapy	99914	1,922	1,650		10.00
10.01	Occupational Therapy	99926	236	124		10.01
11.00	Speech Pathology	99914	208	309		11.00
11.01	Speech Pathology	99926	54	15		11.01
12.00	Medical Social Services	99914	26	43		12.00
12.01	Medical Social Services	99926	4	5		12.01
13.00	Home Health Aide	99914	1,542	3,927		13.00
13.01	Home Health Aide	99926	266	696		13.01
14.00	Total (sum of lines 8-13)		20,846	24,089		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 + col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations

15.00	Cost of Medical Supplies	8.00	0	15,336	15,336	76,716	0.199906	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

Cost Center Description	Program Visits		Cost of Services		Ratio (col. 3 + col. 4)	
	Part A	Part B Not Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance		
	6.00	7.00	8.00	9.00	10.00	11.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION
Cost Per Visit Computation

1.00	Skilled Nursing Care	11,480	12,700	1,561,969	1,727,962		1.00
2.00	Physical Therapy	5,108	4,620	924,701	836,359		2.00
3.00	Occupational Therapy	2,158	1,774	349,445	287,264		3.00
4.00	Speech Pathology	262	324	38,166	47,197		4.00
5.00	Medical Social Services	30	48	92,045	147,273		5.00
6.00	Home Health Aide	1,808	4,623	192,805	492,997		6.00
7.00	Total (sum of lines 1-6)	20,846	24,089	3,159,131	3,539,052		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2012
To 09/30/2013

Worksheet H-3
Part I
Date/Time Prepared:
2/28/2014 2:15 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
14.00	Total (sum of lines 8-13)						14.00
		Program Covered Charges			Cost of Services		
Cost Center Description		Part A	Part B		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		6.00	7.00	8.00	9.00	10.00	11.00
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies						15.00
16.00	Cost of Drugs		0	0		0	16.00
Cost Center Description		Total Program Cost (sum of cols. 9-10)					
		12.00					
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	3,289,931					1.00
2.00	Physical Therapy	1,761,060					2.00
3.00	Occupational Therapy	636,709					3.00
4.00	Speech Pathology	85,363					4.00
5.00	Medical Social Services	239,318					5.00
6.00	Home Health Aide	685,802					6.00
7.00	Total (sum of lines 1-6)	6,698,183					7.00
Cost Center Description							
		12.00					
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet H-3
Part II
Date/Time Prepared:
2/28/2014 2:15 pm

HHA CCN: 147031

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00 Physical Therapy	66.00	0.650258	0	0	0 col. 2, line 2.00	1.00
2.00 Occupational Therapy	67.00	0.384561	0	0	0 col. 2, line 3.00	2.00
3.00 Speech Pathology	68.00	0.307082	0	0	0 col. 2, line 4.00	3.00
4.00 Cost of Medical Supplies	71.00	0.199910	76,716	15,336	0 col. 2, line 15.00	4.00
5.00 Cost of Drugs	73.00	0.195813	0	0	0 col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet H-4
Part I-II
Date/Time Prepared:
2/28/2014 2:15 pm

HHA CCN: 147031

Title XVIII

Home Health
Agency I

PPS

		Part A		Part B	
		Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES					
Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	2,947,681	3,247,527	0	2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	2,947,681	3,247,527	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	2,947,681	3,247,527	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	2,102	0	9.00
		Part A Services		Part B Services	
		1.00		2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)		0	-2,102	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		2,876,455	2,583,585	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		89,495	263,845	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		28,659	27,181	13.00
14.00	Total PPS Reimbursement - PEP Episodes		23,016	18,107	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		25,253	76,659	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	400	16.00
17.00	Total Other Payments		0	0	17.00
18.00	DME Payments		0	0	18.00
19.00	Oxygen Payments		0	0	19.00
20.00	Prosthetic and Orthotic Payments		0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		3,042,878	2,967,675	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		3,042,878	2,967,675	24.00
25.00	Coinsurance billed to program patients (from your records)		0	0	25.00
26.00	Net cost (line 24 minus line 25)		3,042,878	2,967,675	26.00
27.00	Reimbursable bad debts (from your records)				27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)				28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		3,042,878	2,967,675	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)		3,042,878	2,967,675	31.00
31.01	Sequestration adjustment (see instructions)		30,253	31,328	31.01
32.00	Interim payments (see instructions)		3,012,625	2,936,347	32.00
33.00	Tentative settlement (for contractor use only)		0	0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33		0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	0	35.00

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

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2012
To 09/30/2013

worksheet H-5
Date/Time Prepared:
2/28/2014 2:15 pm

Home Health Agency I PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,012,625		2,936,347	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		3,012,625		2,936,347	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		30,253		31,328	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,042,878		2,967,675	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140015

Period:

Worksheet K

Hospice CCN: 141501

From 10/01/2012

Date/Time Prepared:

To 09/30/2013

2/28/2014 2:15 pm

		Hospice I					
		Salaries (from	Employee	Transportation	Contracted	Other	
		Wkst. K-1)	Benefits (from	(see Inst.)	Services (from		
		1.00	Wkst. K-2)		Wkst. K-3)		
			2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0			0
2.00	Capital Related Costs-Movable Equip.			0			0
3.00	Plant Operation and Maintenance	0	0	0	0	0	0
4.00	Transportation - Staff	0	0	0	0	0	0
5.00	Volunteer Service Coordination	0	0	0	0	0	0
6.00	Administrative and General	406,227	0	84,739	0	195,478	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	28,435	0	0	44,500	0	9.00
10.00	Nursing Care	907,231	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	194,368	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	69,128	0	0	62,804	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	131,732	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	38,462	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,605,389	0	84,739	107,304	365,672	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140015

Period:

Worksheet K

Hospice CCN: 141501

From 10/01/2012

Date/Time Prepared:

To 09/30/2013

2/28/2014 2:15 pm

		Hospice I					
		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	686,444	0	686,444	0	686,444	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	72,935	0	72,935	-27,952	44,983	9.00
10.00	Nursing Care	907,231	0	907,231	0	907,231	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	194,368	0	194,368	0	194,368	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	131,932	0	131,932	0	131,932	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	131,732	0	131,732	0	131,732	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	38,462	-259	38,203	0	38,203	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	2,163,104	-259	2,162,845	-27,952	2,134,893	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES		Provider CCN: 140015		Period: From 10/01/2012 To 09/30/2013		Worksheet K-1	
		Hospice CCN: 141501				Date/Time Prepared: 2/28/2014 2:15 pm	
		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	907,231	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	194,368	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	194,368	0	907,231	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140015

Period: From 10/01/2012

Worksheet K-1

Hospice CCN: 141501

To 09/30/2013

Date/Time Prepared: 2/28/2014 2:15 pm

		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	406,227	406,227	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	28,435	28,435	9.00
10.00	Nursing Care		0	0	907,231	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	194,368	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		69,128	0	69,128	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	69,128	434,662	1,605,389	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES		Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	Worksheet K-3	
		Hospice CCN: 141501	Date/Time Prepared: 2/28/2014 2:15 pm		
		Hospice I			
		Administrator	Director	Social Services	Nurses
		1.00	2.00	3.00	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	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	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	0	0	15.00
16.00	Spiritual Counseling	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	17.00
18.00	Counseling - Other	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	20.00
21.00	Other	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS					
22.00	Drugs, Biological and Infusion Therapy				22.00
23.00	Analgesics				23.00
24.00	Sedatives / Hypnotics				24.00
25.00	Other - Specify				25.00
26.00	Durable Medical Equipment/oxygen				26.00
27.00	Patient Transportation	0	0	0	27.00
28.00	Imaging Services	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	29.00
30.00	Medical Supplies	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	32.00
33.00	Chemotherapy	0	0	0	33.00
34.00	Other	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE					
35.00	Bereavement Program Costs	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	36.00
37.00	Fundraising	0	0	0	37.00
38.00	Other Program Costs	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES		Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	Worksheet K-3	
		Hospice CCN: 141501	Date/Time Prepared: 2/28/2014 2:15 pm		
		Hospice I			
		Total Therapists	Aides	All-Other	Total (1)
		6.00	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.				1.00
2.00	Capital Related Costs-Movable Equip.				2.00
3.00	Plant Operation and Maintenance		0	0	3.00
4.00	Transportation - Staff		0	0	4.00
5.00	Volunteer Service Coordination		0	0	5.00
6.00	Administrative and General		0	0	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	44,500	9.00
10.00	Nursing Care		0	0	10.00
11.00	Nursing Care-Continuous Home Care		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	0	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		62,804	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	20.00
21.00	Other		0	0	21.00
OTHER HOSPICE SERVICE COSTS					
22.00	Drugs, Biological and Infusion Therapy				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	27.00
28.00	Imaging Services		0	0	28.00
29.00	Labs and Diagnostics		0	0	29.00
30.00	Medical Supplies		0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	31.00
32.00	Radiation Therapy		0	0	32.00
33.00	Chemotherapy		0	0	33.00
34.00	Other		0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE					
35.00	Bereavement Program Costs		0	0	35.00
36.00	Volunteer Program Costs		0	0	36.00
37.00	Fundraising		0	0	37.00
38.00	Other Program Costs		0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	62,804	44,500	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140015

Period:

Worksheet K-4

Hospice CCN: 141501

From 10/01/2012

Part I

To 09/30/2013

Date/Time Prepared:

2/28/2014 2:15 pm

		CAPITAL RELATED COST				
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION
		0	1.00	2.00	3.00	4.00
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0			1.00
2.00	Capital Related Costs-Movable Equip.	0		0		2.00
3.00	Plant Operation and Maintenance	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	5.00
6.00	Administrative and General	686,444	0	0	0	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	44,983	0	0	0	9.00
10.00	Nursing Care	907,231	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	194,368	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	131,932	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	131,732	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	38,203	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	2,134,893	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140015

Period:

Worksheet K-4

Hospice CCN: 141501

From 10/01/2012

Part I

To 09/30/2013

Date/Time Prepared:

2/28/2014 2:15 pm

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	Hospice I TOTAL (col. 5A ± col. 6)	
		5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance					3.00
4.00	Transportation - staff					4.00
5.00	Volunteer Service Coordination	0				5.00
6.00	Administrative and General	0	686,444	686,444		6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	44,983	21,318	66,301	9.00
10.00	Nursing Care	0	907,231	429,952	1,337,183	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	0	194,368	92,114	286,482	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	131,932	62,525	194,457	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	131,732	62,430	194,162	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	38,203	18,105	56,308	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	2,134,893		2,134,893	39.00

Provider CCN: 140015
 Hospice CCN: 141501

Period:
 From 10/01/2012
 To 09/30/2013

Worksheet K-4
 Part II
 Date/Time Prepared:
 2/28/2014 2:15 pm

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:

Worksheet K-4

Hospice CCN: 141501

From 10/01/2012

Part II

To 09/30/2013

Date/Time Prepared:

2/28/2014 2:15 pm

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-686,444	1,448,449	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	44,983	9.00
10.00	Nursing Care	0	907,231	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	194,368	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	131,932	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	131,732	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	38,203	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per wkst. K-4, Part I)		686,444	39.00
40.00	Unit Cost Multiplier		0.473917	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015

Period: From 10/01/2012

Worksheet K-5

Hospice CCN: 141501

To 09/30/2013

Part I

Hospice I

Date/Time Prepared: 2/28/2014 2:15 pm

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS						
		BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT			
		1.00	1.01	1.02	1.03			
1.00 Administrative and General	0	0	0	0	0	0	0	1.00
2.00 Inpatient - General Care	0	0	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	0	0	3.00
4.00 Physician Services	66,301	0	0	0	0	0	0	4.00
5.00 Nursing Care	1,337,183	0	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	0	0	9.00
10.00 Medical Social Services	286,482	0	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	194,457	0	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	194,162	0	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	0	0	24.00
25.00 Medical Supplies	56,308	0	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	2,134,893	0	0	0	0	0	0	34.00
35.00 Unit Cost Multiplier (see instructions)								35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015

Period: From 10/01/2012

Worksheet K-5

Hospice CCN: 141501

To 09/30/2013

Part I

Date/Time Prepared: 2/28/2014 2:15 pm

Cost Center Description	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	14TH STREET	MOB PHASE I	MVBLE EQUIP				
	1.04	1.05	2.00	4.00			
1.00 Administrative and General	3,977	0	8,633	94,796	107,406	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	6,635	72,936	4.00	
5.00 Nursing Care	0	0	0	211,708	1,548,891	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	45,357	331,839	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	16,131	210,588	14.00	
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00	
16.00 Other	0	0	0	0	0	16.00	
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	194,162	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	56,308	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)	3,977	0	8,633	374,627	2,522,130	34.00	
35.00 Unit Cost Multiplier (see instructions)					0.000000	35.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet K-5
Part I
Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description	Hospice I					DIETARY	
	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING			
	5.00	6.00	8.00	9.00	10.00		
1.00 Administrative and General	28,188	63,097	1,960	22,949	0	0	1.00
2.00 Inpatient - General Care	0	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	0	3.00
4.00 Physician Services	19,142	0	0	0	0	0	4.00
5.00 Nursing Care	406,500	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	0	9.00
10.00 Medical Social Services	87,090	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	55,268	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	50,957	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	14,778	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)	661,923	63,097	1,960	22,949	0	0	34.00
35.00 Unit Cost Multiplier (see instructions)							35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015

Period:

Worksheet K-5

Hospice CCN: 141501

From 10/01/2012

Part I

To 09/30/2013

Date/Time Prepared:

2/28/2014 2:15 pm

		Hospice I					
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES	
		11.00	13.00	16.00	20.00	21.00	
1.00	Administrative and General	87,284	418,927	0	13,415	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	87,284	418,927	0	13,415	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015

Period:

Worksheet K-5

Hospice CCN: 141501

From 10/01/2012

Part I

To 09/30/2013

Date/Time Prepared:

2/28/2014 2:15 pm

Cost Center Description		INTERNS & RESIDENTS	Hospice I			subtotal (cols. 4A-23)	
		SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY		
		22.00	23.00	23.01	23.02	24.00	
1.00	Administrative and General	0	0	0	0	743,226	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	92,078	4.00
5.00	Nursing Care	0	0	0	0	1,955,391	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	418,929	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	265,856	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	245,119	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	71,086	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	3,791,685	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015

Period:

Worksheet K-5

Hospice CCN: 141501

From 10/01/2012

Part I

To 09/30/2013

Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Hospice I	
					Total Hospice Costs (cols. 26 ± 27)	
		25.00	26.00	27.00	28.00	
1.00	Administrative and General					1.00
2.00	Inpatient - General Care	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	3.00
4.00	Physician Services	0	92,078	22,449	114,527	4.00
5.00	Nursing Care	0	1,955,391	476,731	2,432,122	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	9.00
10.00	Medical Social Services	0	418,929	102,137	521,066	10.00
11.00	Spiritual Counseling	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	265,856	64,817	330,673	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	15.00
16.00	Other	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	245,119	59,761	304,880	17.00
18.00	Analgesics	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	24.00
25.00	Medical Supplies	0	71,086	17,331	88,417	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	28.00
29.00	Other	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	3,791,685		3,791,685	34.00
35.00	Unit Cost Multiplier (see instructions)			0.243804		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet K-5
Part II
Date/Time Prepared:
2/28/2014 2:15 pm

Hospice CCN: 141501

Hospice I

Cost Center Description	CAPITAL RELATED COSTS					
	BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BUILDING & FIXT (SQUARE FEET)	NEW BUILDING & FIXT (SQUARE FEET)	14TH STREET (SQUARE FEET)	
	1.00	1.01	1.02	1.03	1.04	
1.00 Administrative and General	0	0	0	0	3,714	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	0	0	0	3,714	34.00
35.00 Total cost to be allocated	0	0	0	0	3,977	35.00
36.00 Unit cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000	1.070813	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2012
To 09/30/2013

Worksheet K-5
Part II
Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		MOB PHASE I (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.05	2.00				
1.00	Administrative and General	0	8,647	406,227	0	107,406	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	28,435	0	72,936	4.00
5.00	Nursing Care	0	0	907,231	0	1,548,891	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	194,368	0	331,839	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	69,128	0	210,588	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, biological and Infusion Therapy	0	0	0	0	194,162	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	56,308	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	8,647	1,605,389		2,522,130	34.00
35.00	Total cost to be allocated	0	8,633	374,627		661,923	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.998381	0.233356		0.262446	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet K-5
Part II
Date/Time Prepared:
2/28/2014 2:15 pm

Hospice CCN: 141501

Cost Center Description	Hospice I					
	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
	6.00	8.00	9.00	10.00	11.00	
1.00 Administrative and General	3,714	2,268	648	0	9,625	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	3,714	2,268	648	0	9,625	34.00
35.00 Total cost to be allocated	63,097	1,960	22,949	0	87,284	35.00
36.00 Unit Cost Multiplier (see instructions)	16.988961	0.864198	35.415123	0.000000	9.068468	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet K-5
Part II
Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description	Hospice I						
	NURSING ADMINISTRATION		MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	INTERNS & RESIDENTS		
	(DIRECT NURS. HRS.)	(TIME SPENT)	(ASSIGNED TIME)	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)		
	13.00	16.00	20.00	21.00	22.00		
1.00 Administrative and General	63,879	0	98	0	0	1.00	
2.00 Inpatient - General Care	0	0	0	0	0	2.00	
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00	
4.00 Physician Services	0	0	0	0	0	4.00	
5.00 Nursing Care	0	0	0	0	0	5.00	
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00	
7.00 Physical Therapy	0	0	0	0	0	7.00	
8.00 Occupational Therapy	0	0	0	0	0	8.00	
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00	
10.00 Medical Social Services	0	0	0	0	0	10.00	
11.00 Spiritual Counseling	0	0	0	0	0	11.00	
12.00 Dietary Counseling	0	0	0	0	0	12.00	
13.00 Counseling - Other	0	0	0	0	0	13.00	
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00	
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00	
16.00 Other	0	0	0	0	0	16.00	
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00	
18.00 Analgesics	0	0	0	0	0	18.00	
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00	
20.00 Other - Specify	0	0	0	0	0	20.00	
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00	
22.00 Patient Transportation	0	0	0	0	0	22.00	
23.00 Imaging Services	0	0	0	0	0	23.00	
24.00 Labs and Diagnostics	0	0	0	0	0	24.00	
25.00 Medical Supplies	0	0	0	0	0	25.00	
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00	
27.00 Radiation Therapy	0	0	0	0	0	27.00	
28.00 Chemotherapy	0	0	0	0	0	28.00	
29.00 Other	0	0	0	0	0	29.00	
30.00 Bereavement Program Costs	0	0	0	0	0	30.00	
31.00 Volunteer Program Costs	0	0	0	0	0	31.00	
32.00 Fundraising	0	0	0	0	0	32.00	
33.00 Other Program Costs	0	0	0	0	0	33.00	
34.00 Total (sum of lines 1 thru 33) (2)	63,879	0	98	0	0	34.00	
35.00 Total cost to be allocated	418,927	0	13,415	0	0	35.00	
36.00 Unit Cost Multiplier (see instructions)	6.558133	0.000000	136.887755	0.000000	0.000000	36.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2012
To 09/30/2013

Worksheet K-5
Part II
Date/Time Prepared:
2/28/2014 2:15 pm

Hospice CCN: 141501

Hospice I

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

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 140015

Period:

Worksheet K-5

Hospice CCN: 141501

From 10/01/2012

Part III

To 09/30/2013

Date/Time Prepared:
2/28/2014 2:15 pm

Cost Center Description	Wkst. C, Part I, col. II line	Cost to Charge Ratio	Hospice I			
			Total Hospice Charges (Provider Records)	Hospice shared Ancillary Costs (cols. 1 x 2)		
	0	1.00	2.00	3.00		
ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.650258	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.384561	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.307082	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.195813	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.119773	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.199910	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00				10.00
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 140015

Period:

worksheet K-6

Hospice CCN: 141501

From 10/01/2012

Date/Time Prepared:

To 09/30/2013

2/28/2014 2:15 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				3,791,685	1.00
2.00	Total Unduplicated Days (worksheet S-9, column 6, line 5)				18,455	2.00
3.00	Average cost per diem (line 1 divided by line 2)				205.46	3.00
4.00	Unduplicated Medicare Days (worksheet S-9, column 1, line 5)	17,345				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	3,563,704				5.00
6.00	Unduplicated Medicaid Days (worksheet S-9, column 2, line 5)		198			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		40,681			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)		71			10.00
11.00	Aggregate NF cost (line 3 times line 10)		14,588			11.00
12.00	Other Unduplicated days (worksheet S-9, column 5, line 5)			912		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			187,380		13.00

Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	Worksheet L Parts I-III Date/Time Prepared: 2/28/2014 2:15 pm
Title XVIII	Hospital	PPS

		1.00	
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	2,978,708	1.00
2.00	Capital DRG outlier payments	124,940	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	101.85	3.00
4.00	Number of interns & residents (see instructions)	16.06	4.00
5.00	Indirect medical education percentage (see instructions)	4.55	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)	135,531	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 (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)	0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)	3,239,179	12.00
		1.00	
PART II - PAYMENT UNDER REASONABLE COST			
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS			
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS
 Provider CCN: 140015
 Component CCN: 143422
 Period: From 10/01/2012 To 09/30/2013
 Worksheet M-1
 Date/Time Prepared: 2/28/2014 2:15 pm

		Rural Health Clinic (RHC) I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	163,168	0	163,168	0	163,168
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	169,968	0	169,968	0	169,968
10.00	Subtotal (sum of lines 1-9)	333,136	0	333,136	0	333,136
11.00	Physician Services Under Agreement	0	292,125	292,125	0	292,125
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	276	276	0	276
14.00	Subtotal (sum of lines 11-13)	0	292,401	292,401	0	292,401
15.00	Medical Supplies	0	0	0	0	0
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	46,799	46,799	-1,171	45,628
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15-20)	0	46,799	46,799	-1,171	45,628
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	333,136	339,200	672,336	-1,171	671,165
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	13,425	13,425	0	13,425
30.00	Administrative Costs	86,198	112,189	198,387	0	198,387
31.00	Total Facility Overhead (sum of lines 29 and 30)	86,198	125,614	211,812	0	211,812
32.00	Total facility costs (sum of lines 22, 28 and 31)	419,334	464,814	884,148	-1,171	882,977

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

Provider CCN: 140015

Period: From 10/01/2012

worksheet M-1

Component CCN: 143422

To 09/30/2013

Date/Time Prepared: 2/28/2014 2:15 pm

Rural Health Clinic (RHC) I

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	163,168	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical social worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	169,968	9.00
10.00	Subtotal (sum of lines 1-9)	0	333,136	10.00
11.00	Physician Services Under Agreement	0	292,125	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	276	13.00
14.00	Subtotal (sum of lines 11-13)	0	292,401	14.00
15.00	Medical Supplies	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	45,628	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	45,628	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	671,165	22.00
COSTS OTHER THAN RHC/FOHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	-40,627	-27,202	29.00
30.00	Administrative Costs	0	198,387	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-40,627	171,185	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-40,627	842,350	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140015

Period: From 10/01/2012

worksheet M-2

Component CCN: 143422

To 09/30/2013

Date/Time Prepared: 2/28/2014 2:15 pm

Rural Health Clinic (RHC) I

Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.00	4,616	4,200	4,200	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.53	2,767	2,100	3,213	3.00
4.00	Subtotal (sum of lines 1-3)	2.53	7,383		7,413	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical social worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	2.53	7,383		7,413	8.00
9.00	Physician Services Under Agreements		0		0	9.00
						1.00

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES			
10.00	Total costs of health care services (from worksheet M-1, column 7, line 22)	671,165	10.00
11.00	Total nonreimbursable costs (from worksheet M-1, column 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	671,165	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total facility overhead - (from worksheet M-1, column 7, line 31)	171,185	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	347,433	15.00
16.00	Total overhead (sum of lines 14 and 15)	518,618	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtract line 17 from line 16	518,618	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	518,618	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	1,189,783	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140015	Period: From 10/01/2012 To 09/30/2013	worksheet M-3
		Component CCN: 143422		Date/Time Prepared: 2/28/2014 2:15 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from worksheet M-2, line 20)		1,189,783	1.00
2.00	Cost of vaccines and their administration (from worksheet M-4, line 15)		15,170	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,174,613	3.00
4.00	Total visits (from worksheet M-2, column 5, line 8)		7,413	4.00
5.00	Physicians visits under agreement (from worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		7,413	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		158.45	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	78.54	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	78.54	79.17	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	634	1,904	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	49,794	150,740	11.00
12.00	Program covered visits for mental health services (from contractor records)	3	22	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	236	1,742	13.00
14.00	Limit adjustment for mental health services (see instructions)	177	1,415	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		202,126	16.00
16.01	Total program charges (see instructions)(from contractor's records)		397,243	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,116	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		568	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		128,562	16.04
16.05	Total program cost (see instructions)		129,130	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		40,856	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		71,792	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		129,130	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, Line 16)		9,783	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		138,913	22.00
23.00	Allowable bad debts (see instructions)		954	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		840	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		131	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		139,753	26.00
26.01	Sequestration adjustment (see instructions)		1,398	26.01
27.00	Interim payments		126,731	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		11,624	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 140015 Component CCN: 143422	Period: From 10/01/2012 To 09/30/2013	Worksheet M-4 Date/Time Prepared: 2/28/2014 2:15 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from worksheet M-1, column 7, line 10)	333,136	333,136	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000334	0.004587	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	111	1,528	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,764	4,154	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,875	5,682	5.00
6.00	Total direct cost of the facility (from worksheet M-1, column 7, line 22)	671,165	671,165	6.00
7.00	Total overhead (from worksheet M-2, line 16)	518,618	518,618	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004284	0.008466	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,222	4,391	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	5,097	10,073	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	31	426	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	164.42	23.65	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	28	219	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	4,604	5,179	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to worksheet M-3, line 2)		15,170	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to worksheet M-3, line 21)		9,783	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:140015 Component CCN:143422	Period: From 10/01/2012 To 09/30/2013	worksheet M-5 Date/Time Prepared: 2/28/2014 2:15 pm
			Rural Health Clinic (RHC) I	Cost
			Part B	
			mm/dd/yyyy	Amount
1.00	Total interim payments paid to provider		1.00	2.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			124,288 0
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			04/18/2013	2,443 3.01
3.02				0 3.02
3.03				0 3.03
3.04				0 3.04
3.05				0 3.05
Provider to Program				
3.50				0 3.50
3.51				0 3.51
3.52				0 3.52
3.53				0 3.53
3.54				0 3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			2,443 3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to worksheet M-3, line 27)			126,731 4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01				0 5.01
5.02				0 5.02
5.03				0 5.03
Provider to Program				
5.50				0 5.50
5.51				0 5.51
5.52				0 5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0 5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER			11,624 6.01
6.02	SETTLEMENT TO PROGRAM			0 6.02
7.00	Total Medicare program liability (see instructions)			138,355 7.00
			Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00 2.00
8.00	Name of Contractor			8.00