

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**  
 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY  
 Provider CCN: 140110  
 Period: From 10/01/2012 To 09/30/2013  
 OMB NO. 0938-0050  
 worksheet 5  
 Parts I-III  
 Date/Time Prepared: 2/27/2014 1:57 pm

**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.  
 Date: 2/27/2014 Time: 1:57 pm

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.

**PART II - CERTIFICATION**

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

**CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)**

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by OTTAWA REGIONAL HOSPITAL & HEALTHCARE ( 140110 ) for the cost reporting period beginning 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: 2/27/2014 Time: 1:57 pm  
 pcQh4ixPonXRkCyIXB3R5riHWYGR10  
 IdFmx0D4UqUBEKx735XoyerWSN8ft9  
 500w1366Yc0wzI.e  
 PI: Date: 2/27/2014 Time: 1:57 pm  
 GN18NWSqx1wrIuuHckBGJz31VPHTH0  
 VCPTS018BvEflCFxrMURC8rRJTKCxh  
 4xBM0lu:Tp0Kznhf

(Signed) *Medellia Haines*  
 Officer or Administrator of Provider(s)  
*Director Debt Management & Revenue Cycle*  
 Title  
 02/28/2014  
 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	189,461	122,093	-79,750	0	1.00
2.00 Subprovider - IPF	0	-444	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	189,017	122,093	-79,750	0	200.00

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

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FORM APPROVED  
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140110	Period: From 10/01/2012 To 09/30/2013	Worksheet S Parts I-III Date/Time Prepared: 2/27/2014 1:54 pm
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**PART I - COST REPORT STATUS**

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

**PART II - CERTIFICATION**

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CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by OTTAWA REGIONAL HOSPITAL & HEALTHCARE ( 140110 ) for the cost reporting period beginning 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.

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)

Title \_\_\_\_\_

Date \_\_\_\_\_

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	189,461	122,093	-79,750	0	1.00
2.00 Subprovider - IPF	0	-444	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	189,017	122,093	-79,750	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140110

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

		1.00	2.00	3.00	4.00					
<b>Hospital and Hospital Health Care Complex Address:</b>										
1.00	Street: 1100 EAST NORRIS DRIVE	PO Box:								1.00
2.00	City: OTTAWA	State: IL		Zip Code: 61350		County: LASALLE				2.00
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
<b>Hospital and Hospital-Based Component Identification:</b>										
3.00	Hospital	OTTAWA REGIONAL HOSPITAL & HEALTHCARE	140110	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	OTTAWA REGIONAL PSYCHIATRIC UNIT	145110	16974	4	05/01/1984	N	P	O	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	OTTAWA VISITING NURSING SERVICE	147048	16974		11/01/1985	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HOSPICE OF COMMUNITY HOSPITAL	141570	16974		02/01/1984				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2012	09/30/2013		20.00
21.00	Type of Control (see instructions)						2			21.00
<b>Inpatient PPS Information</b>										
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.						1	N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	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.	1,455	185	0	0	13	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		25.00	
							Urban/Rural S	Date of Geogr		
							1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0			35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:140110

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	1		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	10/01/2012	09/30/2013	38.00
		Y/N	Y/N	
		1.00	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)	Y	Y	39.00
		V	XVIII	XIX
		1.00	2.00	3.00

<b>Prospective Payment System (PPS)-Capital</b>					
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
<b>Teaching Hospitals</b>					
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	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	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
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

		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			
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>									
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		
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>									
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			
<b>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.</b>									
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
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
		1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name 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			
<b>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</b>									
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	66.00

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name 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
<b>Inpatient Psychiatric Facility PPS</b>						
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
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00
						1.00
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
<b>TEFRA Providers</b>						
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
<b>Title V and XIX Services</b>						
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
<b>Rural Providers</b>						
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:140110		Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part I Date/Time Prepared: 2/27/2014 1:54 pm	
		V 1.00	XIX 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	
<b>Miscellaneous Cost Reporting Information</b>							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.			N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			2			118.00
		Premiums		Losses	Insurance		
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	231,476		0	199,607		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.			N			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.			N		Y	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y			121.00
<b>Transplant Center Information</b>							
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
<b>All Providers</b>							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			Y		149006	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN:140110 Period: From 10/01/2012 To 09/30/2013 Worksheet S-2 Part I Date/Time Prepared: 2/27/2014 1:54 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: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS	Contractor's Number: 00131	141.00
142.00	Street: 800 N.E. GLEN OAK AVENUE	PO Box:		142.00
143.00	City: PEORIA	State: IL	Zip Code: 61603	143.00

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.	N	145.00

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.	1.00	2.00	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	
<b>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)</b>						
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

<b>Multicampus</b>						
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

<b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b>						
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.				Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				1.00	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)	07/01/2013	09/28/2013	170.00

		Y/N	Date	
		1.00	2.00	
<b>General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.</b>				
<b>COMPLETED BY ALL HOSPITALS</b>				
<b>Provider Organization and Operation</b>				
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)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
<b>Financial Data and Reports</b>				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
<b>Approved Educational Activities</b>				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
<b>Bad Debts</b>				
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
<b>Bed Complement</b>				
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
<b>PS&amp;R Data</b>				
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	02/19/2014	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		Y
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		
		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	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>						
<b>Capital Related Cost</b>						
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
<b>Interest Expense</b>						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
<b>Purchased Services</b>						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
<b>Provider-Based Physicians</b>						
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
		Y/N	Date			
		1.00	2.00			
<b>Home Office Costs</b>						
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.	N				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N				40.00
					1.00	2.00
<b>Cost Report Preparer Contact Information</b>						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAWN		TROMPETER		41.00
42.00	Enter the employer/company name of the cost report preparer.	OSF SAINT ELIZABETH MEDICAL CENTER				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-431-5458		DAWN.C.TROMPETER@OSFHEALTHCARE.ORG		43.00

		Part B		
		Date		
		4.00		
<b>PS&amp;R Data</b>				
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)	02/19/2014		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	
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CHIEF FINANCIAL OFFICER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

		Title V 1.00	Title XIX 2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>				
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	
<b>CRITICAL ACCESS HOSPITALS</b>				
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	
<b>RCE DISALLOWANCE</b>				
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
<b>PASS THROUGH COST</b>				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") 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:140110

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
	Line Number				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	68	24,820	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)		68	24,820	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	5	1,825	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	43.00				0	13.00
14.00 Total (see instructions)		73	26,645	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	26	9,490		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	4,454			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		99				27.00
28.00 Observation Bed Days					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)	3,368	945	6,189			1.00
2.00 HMO and other (see instructions)	335	198				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)	3,368	945	6,189			7.00
8.00 INTENSIVE CARE UNIT	526	36	828			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		376	603			13.00
14.00 Total (see instructions)	3,894	1,357	7,620	0.00	494.58	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,660	1,527	5,052	0.00	34.88	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	8,050	0	13,077	0.00	22.79	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	3,523	291	4,454	0.00	3.95	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	556.20	27.00
28.00 Observation Bed Days		122	897			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		98	115			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:140110

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

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	1,162	525	2,328	1.00
2.00 HMO and other (see instructions)				106			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	1,162	525	2,328		14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0	275	401	1,069		16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY	0.00						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							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: 140110

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
2/27/2014 1:54 pm

	Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	30,675,584	0	30,675,584	1,156,046.00	26.53 1.00
2.00	Non-physician anesthetist Part A		721	0	721	8.00	90.13 2.00
3.00	Non-physician anesthetist Part B		182,777	0	182,777	1,992.00	91.76 3.00
4.00	Physician-Part A - Administrative		495,619	0	495,619	5,448.00	90.97 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician-Part B		2,340,416	0	2,340,416	16,174.00	144.70 5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		5,043,431	-1,548,467	3,494,964	156,762.00	22.29 10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor (see instructions)		803,869	0	803,869	14,697.00	54.70 11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		829,559	0	829,559	8,903.00	93.18 13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00 14.00
15.00	Home office: Physician Part A - Administrative		4,255,146	0	4,255,146	84,110.00	50.59 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		8,363,673	0	8,363,673		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		1,105,714	0	1,105,714		
20.00	Non-physician anesthetist Part A		120	0	120		
21.00	Non-physician anesthetist Part B		29,543	0	29,543		
22.00	Physician Part A - Administrative		80,399	0	80,399		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		322,184	0	322,184		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	4.00	309,833	0	309,833	14,868.00	20.84 26.00
27.00	Administrative & General	5.00	4,328,250	23,278	4,351,528	135,557.00	32.10 27.00
28.00	Administrative & General under contract (see inst.)		315,574	0	315,574	1,472.00	214.38 28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00 29.00
30.00	Operation of Plant	7.00	937,660	0	937,660	51,611.00	18.17 30.00
31.00	Laundry & Linen Service	8.00	40,868	0	40,868	3,295.00	12.40 31.00
32.00	Housekeeping	9.00	763,122	0	763,122	63,109.00	12.09 32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00 33.00
34.00	Dietary	10.00	698,862	0	698,862	55,889.00	12.50 34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00 35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00 36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00 37.00
38.00	Nursing Administration	13.00	1,031,164	0	1,031,164	28,719.00	35.91 38.00
39.00	Central Services and Supply	14.00	551,231	-333,693	217,538	5,407.00	40.23 39.00
40.00	Pharmacy	15.00	845,507	0	845,507	24,658.00	34.29 40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN:140110

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
2/27/2014 1:54 pm

	Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00 1,451,500	0	1,451,500	70,102.00	20.71	41.00
42.00	Social Service	17.00 179,485	0	179,485	6,436.00	27.89	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140110

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
2/27/2014 1:54 pm

	Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	28,467,244	0	28,467,244	1,139,344.00	24.99	1.00
2.00	Excluded area salaries (see instructions)	5,043,431	-1,548,467	3,494,964	156,762.00	22.29	2.00
3.00	Subtotal salaries (line 1 minus line 2)	23,423,813	1,548,467	24,972,280	982,582.00	25.41	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,888,574	0	5,888,574	107,710.00	54.67	4.00
5.00	Subtotal wage-related costs (see inst.)	8,444,072	0	8,444,072	0.00	33.81	5.00
6.00	Total (sum of lines 3 thru 5)	37,756,459	1,548,467	39,304,926	1,090,292.00	36.05	6.00
7.00	Total overhead cost (see instructions)	11,453,056	-310,415	11,142,641	461,123.00	24.16	7.00

		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	857,586	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
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
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	6,644,766	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)	-33,700	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)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	234,322	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
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	2,123,727	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	46,610	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
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	28,322	23.00
24.00	Total wage Related cost (Sum of lines 1 -23)	9,901,633	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN:140110

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
2/27/2014 1:54 pm

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

HOME HEALTH AGENCY STATISTICAL DATA	Provider CCN:140110 Component CCN:147048	Period: From 10/01/2012 To 09/30/2013	Worksheet S-4 Date/Time Prepared: 2/27/2014 1:54 pm
		Home Health Agency I	PPS

0.00 County							1.00	0.00				
							LASALLE					
							Other	Total				
							1.00	2.00	3.00	4.00	5.00	
<b>HOME HEALTH AGENCY STATISTICAL DATA</b>												
1.00	Home Health Aide Hours	0	0	0	0	0	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	525.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.00
<b>Number of Employees (Full Time Equivalent)</b>												
Enter the number of hours in your normal work week												
Staff Contract Total												
0 1.00 2.00 3.00												
<b>HOME HEALTH AGENCY - NUMBER OF EMPLOYEES</b>												
3.00	Administrator and Assistant Administrator(s)		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	18.00
<b>HOME HEALTH AGENCY CBSA CODES</b>												
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					1						19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914								20.00
<b>Full Episodes</b>												
Without Outliers With Outliers LUPA Episodes PEP Only Episodes Total (cols. 1-4)												
1.00 2.00 3.00 4.00 5.00												
<b>PPS ACTIVITY DATA</b>												
21.00	Skilled Nursing Visits	3,623	133	221	195	4,172						21.00
22.00	Skilled Nursing Visit Charges	1,041,616	38,969	60,651	55,377	1,196,613						22.00
23.00	Physical Therapy Visits	2,865	5	23	101	2,994						23.00
24.00	Physical Therapy Visit Charges	835,343	1,465	6,739	29,593	873,140						24.00
25.00	Occupational Therapy Visits	141	0	3	12	156						25.00
26.00	Occupational Therapy Visit Charges	41,313	0	879	3,516	45,708						26.00
27.00	Speech Pathology Visits	59	0	0	0	59						27.00
28.00	Speech Pathology Visit Charges	17,287	0	0	0	17,287						28.00
29.00	Medical Social Service Visits	68	0	2	9	79						29.00
30.00	Medical Social Service Visit Charges	19,924	0	586	2,637	23,147						30.00
31.00	Home Health Aide Visits	566	0	2	22	590						31.00
32.00	Home Health Aide Visit Charges	95,322	0	336	3,696	99,354						32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	7,322	138	251	339	8,050						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)	2,050,805	40,434	69,191	94,819	2,255,249						35.00
36.00	Total Number of Episodes (standard/non outlier)	498		82	27	607						36.00
37.00	Total Number of Outlier Episodes		4		0	4						37.00
38.00	Total Non-Routine Medical Supply Charges	87,574	9,668	3,233	5,206	105,681						38.00

HOSPITAL IDENTIFICATION DATA	Provider CCN:140110 Component CCN:141570	Period: From 10/01/2012 To 09/30/2013	Worksheet S-9 Parts I & II Date/Time Prepared: 2/27/2014 1:54 pm
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		Hospice I						
		Unduplicated Oays						
		Title XVIII	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	
<b>PART I - ENROLLMENT DAYS</b>								
1.00	Continuous Home Care	1	0	0	0	0	1	1.00
2.00	Routine Home Care	3,451	265	368	68	628	4,344	2.00
3.00	Inpatient Respite Care	28	0	4	0	0	28	3.00
4.00	General Inpatient Care	43	26	0	23	12	81	4.00
5.00	Total Hospice Days	3,523	291	372	91	640	4,454	5.00
<b>PART II - CENSUS DATA</b>								
6.00	Number of Patients Receiving Hospice Care	86	5	12	2	40	131	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	13.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	40.97	58.20	31.00	45.50	16.00	34.00	8.00
9.00	Unduplicated Census Count	88	5	11	2	12	105	9.00

		1.00		
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.361587	1.00
<b>Medicaid (see instructions for each line)</b>				
2.00	Net revenue from Medicaid		8,250,551	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		2,240,478	5.00
6.00	Medicaid charges		29,807,473	6.00
7.00	Medicaid cost (line 1 times line 6)		10,777,995	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)		286,966	8.00
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>				
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
<b>Other state or local government indigent care program (see instructions for each line)</b>				
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
<b>Uncompensated care (see instructions for each line)</b>				
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)		286,966	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	7,492,454	0	7,492,454
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,709,174	0	2,709,174
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	2,709,174	0	2,709,174
		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)		4,864,450	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		461,637	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)		4,402,813	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,592,000	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		4,301,174	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,588,140	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140110

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

Worksheet A

Date/Time Prepared:  
2/27/2014 1:54 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	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS-BLDG & FIXT		-1,062,749	-1,062,749	45,002	-1,017,747	1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		4,160,940	4,160,940	22,502	4,183,442	2.00
3.00 00300 OTHER CAP REL COSTS		0	0	0	0	3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	309,833	9,979,465	10,289,298	0	10,289,298	4.00
5.00 00500 ADMINISTRATIVE & GENERAL	4,328,250	10,326,993	14,655,243	-44,257	14,610,986	5.00
7.00 00700 OPERATION OF PLANT	937,660	1,452,585	2,390,245	-13,528	2,376,717	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	40,868	229,521	270,389	0	270,389	8.00
9.00 00900 HOUSEKEEPING	763,122	136,750	899,872	62	899,934	9.00
10.00 01000 DIETARY	698,862	745,743	1,444,605	0	1,444,605	10.00
11.00 01100 CAFETERIA	0	0	0	0	0	11.00
13.00 01300 NURSING ADMINISTRATION	1,031,164	70,492	1,101,656	0	1,101,656	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	551,231	465,607	1,016,838	-649,059	367,779	14.00
15.00 01500 PHARMACY	845,507	1,587,848	2,433,355	-1,487,556	945,799	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1,451,500	440,094	1,891,594	0	1,891,594	16.00
17.00 01700 SOCIAL SERVICE	179,485	8,751	188,236	0	188,236	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	223,636	223,636	19.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	2,768,824	215,655	2,984,479	-595,692	2,388,787	30.00
31.00 03100 INTENSIVE CARE UNIT	697,749	40,004	737,753	0	737,753	31.00
40.00 04000 SUBPROVIDER - IPF	3,425,944	188,880	3,614,824	-1,639,806	1,975,018	40.00
43.00 04300 NURSERY	53,236	17,419	70,655	125,958	196,613	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	580,338	3,269,387	3,849,725	-626,012	3,223,713	50.00
51.00 05100 RECOVERY ROOM	167,701	4,785	172,486	0	172,486	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	376,203	376,203	52.00
53.00 05300 ANESTHESIOLOGY	1,738,272	245,534	1,983,806	-223,636	1,760,170	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,901,642	1,134,506	3,036,148	-7,393	3,028,755	54.00
58.00 05800 MRI	175,269	151,174	326,443	0	326,443	58.00
60.00 06000 LABORATORY	935,271	1,596,372	2,531,643	0	2,531,643	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	471,850	471,850	64.00
65.00 06500 RESPIRATORY THERAPY	527,879	123,362	651,241	0	651,241	65.00
66.00 06600 PHYSICAL THERAPY	1,596,213	277,020	1,873,233	0	1,873,233	66.00
67.00 06700 OCCUPATIONAL THERAPY	85,347	84,760	170,107	0	170,107	67.00
68.00 06800 SPEECH PATHOLOGY	61,101	110,896	171,997	13,454	185,451	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	193,332	193,332	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	7,498	7,498	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	177,209	177,209	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	719,543	719,543	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	1,487,556	1,487,556	73.00
75.00 07500 ASC (NON-DISTINCT PART)	1,813,135	725,882	2,539,017	-524,979	2,014,038	75.00
76.00 03160 STRESS TESTING	0	0	0	0	0	76.00
76.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	218,784	2,422	221,206	1,639,806	1,861,012	76.01
76.97 07697 CARDIAC REHABILITATION	0	0	0	289,062	289,062	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100 EMERGENCY	1,173,910	1,210,493	2,384,403	-41,226	2,343,177	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100 HOME HEALTH AGENCY	1,423,493	269,447	1,692,940	5,229	1,698,169	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE		0	0	0	0	113.00
116.00 11600 HOSPICE	193,994	176,724	370,718	355	371,073	116.00
117.00 06950 HOMEMAKER	0	0	0	0	0	117.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	30,675,584	38,386,762	69,062,346	-54,887	69,007,459	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	-327,866	-327,866	54,887	-272,979	192.00
200.00 TOTAL (SUM OF LINES 118-199)	30,675,584	38,058,896	68,734,480	0	68,734,480	200.00

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100 CAP REL COSTS-BLDG & FIXT	2,922,578	1,904,831	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	4,183,442	2.00
3.00	00300 OTHER CAP REL COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-4,823	10,284,475	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-645,679	13,965,307	5.00
7.00	00700 OPERATION OF PLANT	0	2,376,717	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	270,389	8.00
9.00	00900 HOUSEKEEPING	0	899,934	9.00
10.00	01000 DIETARY	-451,281	993,324	10.00
11.00	01100 CAFETERIA	0	0	11.00
13.00	01300 NURSING ADMINISTRATION	-150	1,101,506	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-50	367,729	14.00
15.00	01500 PHARMACY	0	945,799	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-3,572	1,888,022	16.00
17.00	01700 SOCIAL SERVICE	0	188,236	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	-223,636	0	19.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS	-15,688	2,373,099	30.00
31.00	03100 INTENSIVE CARE UNIT	0	737,753	31.00
40.00	04000 SUBPROVIDER - IPF	-7,320	1,967,698	40.00
43.00	04300 NURSERY	0	196,613	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	-598	3,223,115	50.00
51.00	05100 RECOVERY ROOM	0	172,486	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	376,203	52.00
53.00	05300 ANESTHESIOLOGY	-1,407,026	353,144	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-7,690	3,021,065	54.00
58.00	05800 MRI	0	326,443	58.00
60.00	06000 LABORATORY	0	2,531,643	60.00
64.00	06400 INTRAVENOUS THERAPY	0	471,850	64.00
65.00	06500 RESPIRATORY THERAPY	0	651,241	65.00
66.00	06600 PHYSICAL THERAPY	-26,666	1,846,567	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	170,107	67.00
68.00	06800 SPEECH PATHOLOGY	0	185,451	68.00
69.00	06900 ELECTROCARDIOLOGY	-57,065	136,267	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	7,498	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	177,209	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	719,543	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-10,432	1,477,124	73.00
75.00	07500 ASC (NON-DISTINCT PART)	-79,403	1,934,635	75.00
76.00	03160 STRESS TESTING	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-967,116	893,896	76.01
76.97	07697 CARDIAC REHABILITATION	0	289,062	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100 EMERGENCY	-200,978	2,142,199	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00	10100 HOME HEALTH AGENCY	-1,213	1,696,956	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE	0	0	113.00
116.00	11600 HOSPICE	-18,848	352,225	116.00
117.00	06950 HOMEMAKER	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,206,656	67,800,803	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	-272,979	192.00
200.00	TOTAL (SUM OF LINES 118-199)	-1,206,656	67,527,824	200.00

COST CENTERS USED IN COST REPORT

Provider CCN:140110

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

Worksheet Non-CMS W

Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
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
7.00	OPERATION OF PLANT	00700		7.00
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
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
23.00	PARAMED ED PRGM-(SPECIFY)	02300		23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
43.00	NURSERY	04300		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
58.00	MRI	05800		58.00
60.00	LABORATORY	06000		60.00
64.00	INTRAVENOUS THERAPY	06400		64.00
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 PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
75.00	ASC (NON-DISTINCT PART)	07500		75.00
76.00	STRESS TESTING	03160		76.00
76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	03550		76.01
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00	HOME HEALTH AGENCY	10100		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	INTEREST EXPENSE	11300		113.00
116.00	HOSPICE	11600		116.00
117.00	HOMEMAKER	06950		117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
200.00	TOTAL (SUM OF LINES 118-199)			200.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
<b>A - INSURANCE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	45,002	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	22,502	2.00
	TOTALS		0	67,504	
<b>B - DELIVERY ROOM AND NURSERY</b>					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	406,940	62,794	1.00
2.00	NURSERY	43.00	109,120	16,838	2.00
	TOTALS		516,060	79,632	
<b>C - EKG HOLTER, STRESS, EEG</b>					
1.00	ELECTROCARDIOLOGY	69.00	136,267	57,065	1.00
2.00	CARDIAC REHABILITATION	76.97	91,256	197,806	2.00
3.00	ELECTROENCEPHALOGRAPHY	70.00	1,877	0	3.00
	TOTALS		229,400	254,871	
<b>D - ER WARD CLERKS</b>					
1.00	EMERGENCY	91.00	48,291	0	1.00
	TOTALS		48,291	0	
<b>I - C-SECTION</b>					
1.00	OPERATING ROOM	50.00	81,028	12,503	1.00
	TOTALS		81,028	12,503	
<b>K - NONPHYSICIAN ANESTHETISTS</b>					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	183,498	1.00
2.00	NONPHYSICIAN ANESTHETISTS	19.00	0	40,138	2.00
	TOTALS		0	223,636	
<b>M - MOB HOSPITAL STORAGE</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	27,799	1.00
	TOTALS		0	27,799	
<b>D - PSYCH ADMIN</b>					
1.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01	518,017	0	1.00
2.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01	1,108,236	0	2.00
3.00	SUBPROVIDER - IPF	40.00	72,215	0	3.00
4.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01	0	85,768	4.00
	TOTALS		1,698,468	85,768	
<b>U - NORRIS BUILDING</b>					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	80,387	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
	TOTALS		0	80,387	
<b>V - MERCURY CIRCLE BUILDING</b>					
1.00	HOUSEKEEPING	9.00	0	62	1.00
2.00	ELECTROENCEPHALOGRAPHY	70.00	0	5,621	2.00
3.00	HOME HEALTH AGENCY	101.00	0	5,229	3.00
4.00	HOSPICE	116.00	0	355	4.00
	TOTALS		0	11,267	
<b>W - RADIOLOGY SPACE</b>					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,333	1.00
	TOTALS		0	1,333	
<b>Y - GLOBAL BILLING</b>					
1.00	SPEECH PATHOLOGY	68.00	11,435	4,814	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	5,571	9,328	2.00
	TOTALS		17,006	14,142	
<b>Z - IV THERAPY</b>					
1.00	INTRAVENOUS THERAPY	64.00	333,693	138,157	1.00
	TOTALS		333,693	138,157	
<b>AA - EMS</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	71,569	17,948	1.00
	TOTALS		71,569	17,948	
<b>AB - MED SUPPLIES SOLD IMPLANTS AND DRUGS</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	177,209	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	719,543	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,487,556	3.00
	TOTALS		0	2,384,308	
500.00	Grand Total: Increases		2,995,515	3,399,255	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - INSURANCE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	67,504	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	67,504			
<b>B - DELIVERY ROOM AND NURSERY</b>							
1.00	ADULTS & PEDIATRICS	30.00	516,060	79,632	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		516,060	79,632			
<b>C - EKG HOLTER, STRESS, EEG</b>							
1.00	ASC (NON-DISTINCT PART)	75.00	229,400	254,871	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		229,400	254,871			
<b>D - ER WARD CLERKS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	48,291	0	0		1.00
	TOTALS		48,291	0			
<b>I - C-SECTION</b>							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	81,028	12,503	0		1.00
	TOTALS		81,028	12,503			
<b>K - NONPHYSICIAN ANESTHETISTS</b>							
1.00	ANESTHESIOLOGY	53.00	0	183,498	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	40,138	0		2.00
	TOTALS		0	223,636			
<b>M - MOB HOSPITAL STORAGE</b>							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	27,799	0		1.00
	TOTALS		0	27,799			
<b>O - PSYCH ADMIN</b>							
1.00	SUBPROVIDER - IPF	40.00	1,626,253	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01	72,215	0	0		3.00
4.00	SUBPROVIDER - IPF	40.00	0	85,768	0		4.00
	TOTALS		1,698,468	85,768			
<b>U - NORRIS BUILDING</b>							
1.00	OPERATION OF PLANT	7.00	0	13,528	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,726	0		2.00
3.00	SPEECH PATHOLOGY	68.00	0	2,795	0		3.00
4.00	ASC (NON-DISTINCT PART)	75.00	0	9,560	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	45,778	0		5.00
	TOTALS		0	80,387			
<b>V - MERCURY CIRCLE BUILDING</b>							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	11,267	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	11,267			
<b>W - RADIOLOGY SPACE</b>							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,333	0		1.00
	TOTALS		0	1,333			
<b>Y - GLOBAL BILLING</b>							
1.00	ASC (NON-DISTINCT PART)	75.00	17,006	14,142	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		17,006	14,142			
<b>Z - IV THERAPY</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	333,693	138,157	0		1.00
	TOTALS		333,693	138,157			
<b>AA - EMS</b>							
1.00	EMERGENCY	91.00	71,569	17,948	0		1.00
	TOTALS		71,569	17,948			
<b>AB - MED SUPPLIES SOLD IMPLANTS AND DRUGS</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	177,209	0		1.00
2.00	OPERATING ROOM	50.00	0	719,543	0		2.00
3.00	PHARMACY	15.00	0	1,487,556	0		3.00
	TOTALS		0	2,384,308			
500.00	Grand Total: Decreases		2,995,515	3,399,255			500.00

RECLASSIFICATIONS

Provider CCN:140110

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

Worksheet A-6  
Non-CMS Worksheet  
Date/Time Prepared:  
2/27/2014 1:54 pm

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
<b>A - INSURANCE</b>						
1.00						
	1.00		ADMINISTRATIVE & GENERAL	5.00	0	1.00
2.00	2.00			0.00	0	2.00
			TOTALS		0	
<b>B - DELIVERY ROOM AND NURSERY</b>						
1.00	52.00	406,940	ADULTS & PEDIATRICS	30.00	516,060	1.00
2.00	43.00	109,120		0.00	0	2.00
		516,060	TOTALS		516,060	
<b>C - EKG HOLTER, STRESS, EEG</b>						
1.00	69.00	136,267	ASC (NON-DISTINCT PART)	75.00	229,400	1.00
2.00	76.97	91,256		0.00	0	2.00
3.00	70.00	1,877		0.00	0	3.00
		229,400	TOTALS		229,400	
<b>D - ER WARD CLERKS</b>						
1.00	91.00	48,291	ADMINISTRATIVE & GENERAL	5.00	48,291	1.00
		48,291	TOTALS		48,291	
<b>I - C-SECTION</b>						
1.00	50.00	81,028	DELIVERY ROOM & LABOR ROOM	52.00	81,028	1.00
		81,028	TOTALS		81,028	
<b>K - NONPHYSICIAN ANESTHETISTS</b>						
1.00	19.00	0	ANESTHESIOLOGY	53.00	0	1.00
2.00	19.00	0	ANESTHESIOLOGY	53.00	0	2.00
		0	TOTALS		0	
<b>M - MOB HOSPITAL STORAGE</b>						
1.00	5.00	0	PHYSICIANS' PRIVATE OFFICES	192.00	0	1.00
		0	TOTALS		0	
<b>O - PSYCH ADMIN</b>						
1.00	76.01	518,017	SUBPROVIDER - IPF	40.00	1,626,253	1.00
2.00	76.01	1,108,236		0.00	0	2.00
3.00	40.00	72,215	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01	72,215	3.00
4.00	76.01	0	SUBPROVIDER - IPF	40.00	0	4.00
		1,698,468	TOTALS		1,698,468	
<b>U - NORRIS BUILDING</b>						
1.00	192.00	0	OPERATION OF PLANT	7.00	0	1.00
2.00	0.00	0	RADIOLOGY-DIAGNOSTIC	54.00	0	2.00
3.00	0.00	0	SPEECH PATHOLOGY	68.00	0	3.00
4.00	0.00	0	ASC (NON-DISTINCT PART)	75.00	0	4.00
5.00	0.00	0	ADMINISTRATIVE & GENERAL	5.00	0	5.00
		0	TOTALS		0	
<b>V - MERCURY CIRCLE BUILDING</b>						
1.00	9.00	0	PHYSICIANS' PRIVATE OFFICES	192.00	0	1.00
2.00	70.00	0		0.00	0	2.00
3.00	101.00	0		0.00	0	3.00
4.00	116.00	0		0.00	0	4.00
		0	TOTALS		0	
<b>W - RADIOLOGY SPACE</b>						
1.00	54.00	0	PHYSICIANS' PRIVATE OFFICES	192.00	0	1.00
		0	TOTALS		0	
<b>Y - GLOBAL BILLING</b>						
1.00	68.00	11,435	ASC (NON-DISTINCT PART)	75.00	17,006	1.00
2.00	192.00	5,571		0.00	0	2.00
		17,006	TOTALS		17,006	
<b>Z - IV THERAPY</b>						
1.00	64.00	333,693	CENTRAL SERVICES & SUPPLY	14.00	333,693	1.00
		333,693	TOTALS		333,693	
<b>AA - EMS</b>						
1.00	5.00	71,569	EMERGENCY	91.00	71,569	1.00
		71,569	TOTALS		71,569	
<b>AB - MED SUPPLIES SOLD IMPLANTS AND DRUGS</b>						
1.00	71.00	0	CENTRAL SERVICES & SUPPLY	14.00	0	1.00
2.00	72.00	0	OPERATING ROOM	50.00	0	2.00
3.00	73.00	0	PHARMACY	15.00	0	3.00
		0	TOTALS		0	
500.00		2,995,515	Grand Total: Increases		2,995,515	500.00
			Grand Total: Decreases			

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:140110

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	3,123,081	0	0	0	1.00
2.00	Land Improvements	2,862,859	0	0	0	2.00
3.00	Buildings and Fixtures	70,785,387	1,275,410	0	1,275,410	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	39,016,720	355,319	0	355,319	6.00
7.00	HIT designated Assets	694,477	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	116,482,524	1,630,729	0	1,630,729	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	116,482,524	1,630,729	0	1,630,729	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	3,123,081	0			1.00
2.00	Land Improvements	2,862,859	0			2.00
3.00	Buildings and Fixtures	72,060,797	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	39,372,039	0			6.00
7.00	HIT designated Assets	694,477	0			7.00
8.00	Subtotal (sum of lines 1-7)	118,113,253	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	118,113,253	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140110

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
2/27/2014 1:54 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	
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	CAP REL COSTS-BLDG & FIXT	-1,098,374	0	35,625	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,160,940	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,062,566	0	35,625	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	CAP REL COSTS-BLDG & FIXT	0	-1,062,749				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,160,940				2.00
3.00	Total (sum of lines 1-2)	0	3,098,191				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140110

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
2/27/2014 1:54 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		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	78,741,214	0	78,741,214	0.666659	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	39,372,039	0	39,372,039	0.333341	0	2.00
3.00	Total (sum of lines 1-2)	118,113,253	0	118,113,253	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		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,253,000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,160,940	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,413,940	0	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		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	-393,171	45,002	0	0	1,904,831	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	22,502	0	0	4,183,442	2.00
3.00	Total (sum of lines 1-2)	-393,171	67,504	0	0	6,088,273	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.	
			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
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)		0		0.00	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	-75,759	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,750,530			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	1,943,840			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-450,673	DIETARY	10.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-50	CENTRAL SERVICES & SUPPLY	14.00	0	16.00
17.00 Sale of drugs to other than patients	B	-10,432	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00 Sale of medical records and abstracts	B	-3,572	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)	B	-5,631	RADIOLOGY-DIAGNOSTIC	54.00	0	19.00
20.00 Vending machines	B	-425	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
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist	A	-223,636	NONPHYSICIAN ANESTHETISTS	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

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	
32.00	CAH HIT Adjustment for Depreciation and Interest	0			0.00		0	32.00
33.00	AMORTIZED CAPITALIZED INTEREST	-34,137	CAP REL COSTS-BLDG & FIXT	1.00			11	33.00
33.01	PHYSICIAN RECRUITING EXPENSE	-4,823	EMPLOYEE BENEFITS DEPARTMENT	4.00			0	33.01
33.02	PATIENT TRANSPORTATION	-22,717	ADMINISTRATIVE & GENERAL	5.00			0	33.02
33.03	TRUSTEE FEES	3,840	ADMINISTRATIVE & GENERAL	5.00			0	33.03
33.04	ADMINISTRATION ALCOHOL	-2,461	ADMINISTRATIVE & GENERAL	5.00			0	33.04
33.05	FOOD SERVICE ALCOHOL	-183	DIETARY	10.00			0	33.05
33.06	ADVERTISING	-12,843	ADMINISTRATIVE & GENERAL	5.00			0	33.06
33.07	AHA LOBBYING FEES	-23,249	ADMINISTRATIVE & GENERAL	5.00			0	33.07
33.08	IHA LOBBYING FEES	-4,490	ADMINISTRATIVE & GENERAL	5.00			0	33.08
33.09	IL HOME CARE LOBBYING FEES	-163	HOSPICE	116.00			0	33.09
33.10	PHYSICIAN LOAN WRITE OFF	-39,410	ADMINISTRATIVE & GENERAL	5.00			0	33.10
33.11	ROTARY FEES	-2,369	ADMINISTRATIVE & GENERAL	5.00			0	33.11
33.12	PHYSICIAN RECRUITING EXPENSE	-575	ADMINISTRATIVE & GENERAL	5.00			0	33.12
33.13	CONTRIBUTIONS / DONATIONS	-150	ADMINISTRATIVE & GENERAL	5.00			0	33.13
33.14	PHYSICIAN RELATED COST	-997	ADMINISTRATIVE & GENERAL	5.00			0	33.14
33.15	MEDICAID TAX ASSESSMENT - APPEA	-2,684,458	ADMINISTRATIVE & GENERAL	5.00			0	33.15
33.16	NONALLOWABLE BOARD EXPENSE	-126	ADMINISTRATIVE & GENERAL	5.00			0	33.16
33.17	COMMUNITY EDUCATION REVENUE	-17,229	ADMINISTRATIVE & GENERAL	5.00			0	33.17
33.18	RENT REVENUE	-8,500	ASC (NON-DISTINCT PART)	75.00			0	33.18
33.19	EDUCATION REVENUE	-150	NURSING ADMINISTRATION	13.00			0	33.19
33.20	HOSPICE MISC REVENUE	-845	HOSPICE	116.00			0	33.20
33.21	RADIOLOGY FILM COPY REVENUE	-2,059	RADIOLOGY-DIAGNOSTIC	54.00			0	33.21
33.22	MISCELLANEOUS REVENUE	-152,599	ADMINISTRATIVE & GENERAL	5.00			0	33.22
33.23	MISCELLANEOUS REVENUE	-2,830	EMERGENCY	91.00			0	33.23
33.24	INTEREST/INVESTMENT INCOME OFFSET	-359,034	CAP REL COSTS-BLDG & FIXT	1.00			11	33.24
33.25	ASSET REDUCTION ADD-BACK	3,761,822	CAP REL COSTS-BLDG & FIXT	1.00			9	33.25
33.26	HHA PHYSICIAN FEES	-1,189	HOME HEALTH AGENCY	101.00			0	33.26
33.27	HHA MEDICAL RECORDS REVENUE	-24	HOME HEALTH AGENCY	101.00			0	33.27
33.28	HOSPICE PHYSICIAN FEES	-17,840	HOSPICE	116.00			0	33.28
33.29		0		0.00			0	33.29
33.30		0		0.00			0	33.30
33.31		0		0.00			0	33.31
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	-1,206,656						50.00

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

Provider CCN: 140110

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

Worksheet A-8-1  
Date/Time Prepared:  
2/27/2014 1:54 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	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	0	35,625 1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	CORPORATE ALLOCATIONS	0	410,448 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	CORPORATE ALLOCATIONS	0	4,052,041 3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	1,323,693	0 4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	NEW BLDG EXPENSE	160,529	0 4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	NEW MME EXPENSE	1,444,794	0 4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	NONCAPITAL EXPENSE	3,512,938	0 4.03
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.			6,441,954	4,498,114 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	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
<b>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>				

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

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

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

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

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

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>			
1.00	-35,625	11	1.00
2.00	-410,448	9	2.00
3.00	-4,052,041	0	3.00
4.00	1,323,693	0	4.00
4.01	160,529	0	4.01
4.02	1,444,794	0	4.02
4.03	3,512,938	0	4.03
5.00	1,943,840		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	HOME OFFICE	6.00
7.00		7.00
8.00		8.00
9.00		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.

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	182,001	170,037	11,964	154,100	140	1.00
2.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	198,987	185,906	13,081	154,100	82	2.00
3.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	318,840	297,881	20,959	154,100	226	3.00
4.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	306,628	286,471	20,157	154,100	83	4.00
5.00	53.00	ANESTHESIOLOGY	372,874	310,189	62,685	200,300	350	5.00
6.00	53.00	ANESTHESIOLOGY	369,366	322,250	47,116	200,300	265	6.00
7.00	53.00	ANESTHESIOLOGY	361,839	356,272	5,567	200,300	32	7.00
8.00	53.00	ANESTHESIOLOGY	337,268	296,420	40,848	200,300	233	8.00
9.00	53.00	ANESTHESIOLOGY	58,895	44,087	14,808	200,300	88	9.00
10.00	75.00	ASC (NON-DISTINCT PART)	329,337	70,903	258,434	177,200	3,949	10.00
11.00	30.00	ADULTS & PEDIATRICS	15,688	15,688	0	0	0	11.00
12.00	40.00	SUBPROVIDER - IPF	7,320	7,320	0	0	0	12.00
13.00	50.00	OPERATING ROOM	598	598	0	0	0	13.00
14.00	60.00	LABORATORY	101,602	0	101,602	215,700	1,950	14.00
15.00	69.00	ELECTROCARDIOLOGY	57,065	57,065	0	0	0	15.00
16.00	66.00	PHYSICAL THERAPY	13,333	0	13,333	177,200	246	16.00
17.00	66.00	PHYSICAL THERAPY	26,666	26,666	0	0	0	17.00
18.00	91.00	EMERGENCY	714,624	0	714,624	177,200	6,707	18.00
19.00	91.00	EMERGENCY	54,909	54,909	0	0	0	19.00
200.00			3,827,840	2,502,662	1,325,178		14,351	200.00

	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	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	10,372	519	0	0	0	1.00
2.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,075	304	0	0	0	2.00
3.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	16,744	837	0	0	0	3.00
4.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,149	307	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	33,704	1,685	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	25,519	1,276	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	3,082	154	0	0	0	7.00
8.00	53.00	ANESTHESIOLOGY	22,437	1,122	0	0	0	8.00
9.00	53.00	ANESTHESIOLOGY	8,474	424	0	0	0	9.00
10.00	75.00	ASC (NON-DISTINCT PART)	336,424	16,821	0	0	0	10.00
11.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	11.00
12.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	12.00
13.00	50.00	OPERATING ROOM	0	0	0	0	0	13.00
14.00	60.00	LABORATORY	202,219	10,111	0	0	0	14.00
15.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	15.00
16.00	66.00	PHYSICAL THERAPY	20,957	1,048	0	0	0	16.00
17.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	17.00
18.00	91.00	EMERGENCY	571,385	28,569	0	0	0	18.00
19.00	91.00	EMERGENCY	0	0	0	0	0	19.00
200.00			1,263,541	63,177	0	0	0	200.00

	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	
1.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	10,372	1,592	171,629	1.00
2.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	6,075	7,006	192,912	2.00
3.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	16,744	4,215	302,096	3.00
4.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	6,149	14,008	300,479	4.00
5.00	53.00	ANESTHESIOLOGY	0	33,704	28,981	339,170	5.00
6.00	53.00	ANESTHESIOLOGY	0	25,519	21,597	343,847	6.00
7.00	53.00	ANESTHESIOLOGY	0	3,082	2,485	358,757	7.00
8.00	53.00	ANESTHESIOLOGY	0	22,437	18,411	314,831	8.00
9.00	53.00	ANESTHESIOLOGY	0	8,474	6,334	50,421	9.00
10.00	75.00	ASC (NON-DISTINCT PART)	0	336,424	0	70,903	10.00
11.00	30.00	ADULTS & PEDIATRICS	0	0	0	15,688	11.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN:140110

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

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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		
12.00	40.00	SUBPROVIDER - IPF	0	0	0	7,320		12.00
13.00	50.00	OPERATING ROOM	0	0	0	598		13.00
14.00	60.00	LABORATORY	0	202,219	0	0		14.00
15.00	69.00	ELECTROCARDIOLOGY	0	0	0	57,065		15.00
16.00	66.00	PHYSICAL THERAPY	0	20,957	0	0		16.00
17.00	66.00	PHYSICAL THERAPY	0	0	0	26,666		17.00
18.00	91.00	EMERGENCY	0	571,385	143,239	143,239		18.00
19.00	91.00	EMERGENCY	0	0	0	54,909		19.00
200.00			0	1,263,541	247,868	2,750,530		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140110

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		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,904,831	1,904,831			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	4,183,442		4,183,442		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	10,284,475	11,235	634	10,296,344	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	13,965,307	125,444	600,698	1,475,494	5.00
7.00 00700	OPERATION OF PLANT	2,376,717	712,468	54,077	317,940	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	270,389	9,494	0	13,857	8.00
9.00 00900	HOUSEKEEPING	899,934	14,291	3,874	258,758	9.00
10.00 01000	DIETARY	993,324	80,080	9,068	236,969	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,101,506	11,933	8,796	349,645	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	367,729	47,307	132,396	73,762	14.00
15.00 01500	PHARMACY	945,799	12,237	65,402	286,693	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,888,022	38,137	64,470	492,172	16.00
17.00 01700	SOCIAL SERVICE	188,236	4,504	157	60,859	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	2,373,099	174,734	85,839	763,863	30.00
31.00 03100	INTENSIVE CARE UNIT	737,753	19,403	12,546	236,591	31.00
40.00 04000	SUBPROVIDER - IPF	1,967,698	69,108	153,773	634,722	40.00
43.00 04300	NURSERY	196,613	0	1,077	55,051	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	3,223,115	69,837	275,375	224,255	50.00
51.00 05100	RECOVERY ROOM	172,486	7,490	3,697	56,864	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	376,203	0	0	110,510	52.00
53.00 05300	ANESTHESIOLOGY	353,144	0	19,727	589,410	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,021,065	68,046	910,093	644,805	54.00
58.00 05800	MRI	326,443	21,255	249,414	59,430	58.00
60.00 06000	LABORATORY	2,531,643	63,835	35,598	317,130	60.00
64.00 06400	INTRAVENOUS THERAPY	471,850	0	0	113,148	64.00
65.00 06500	RESPIRATORY THERAPY	651,241	11,994	25,164	178,992	65.00
66.00 06600	PHYSICAL THERAPY	1,846,567	152,963	56,256	541,241	66.00
67.00 06700	OCCUPATIONAL THERAPY	170,107	8,603	0	28,939	67.00
68.00 06800	SPEECH PATHOLOGY	185,451	4,838	10,107	24,595	68.00
69.00 06900	ELECTROCARDIOLOGY	136,267	0	0	46,205	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	7,498	7,075	15,896	636	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	177,209	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	719,543	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,477,124	0	0	0	73.00
75.00 07500	ASC (NON-DISTINCT PART)	1,934,635	77,175	175,090	531,243	75.00
76.00 03160	STRESS TESTING	0	0	0	0	76.00
76.01 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	893,896	39,564	289,618	601,125	76.01
76.97 07697	CARDIAC REHABILITATION	289,062	0	0	30,943	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	2,142,199	41,781	80,022	390,154	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100	HOME HEALTH AGENCY	1,696,956	0	68,455	482,675	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	352,225	0	1,005	65,779	116.00
117.00 06950	HOMEMAKER	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	67,800,803	1,904,831	3,408,324	10,294,455	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	-272,979	0	775,118	1,889	192.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118-201)	67,527,824	1,904,831	4,183,442	10,296,344	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140110

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

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Part I  
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Cost Center Description		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	16,166,943					5.00
7.00	00700 OPERATION OF PLANT	1,089,489	4,550,691				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	92,461	40,925	427,126			8.00
9.00	00900 HOUSEKEEPING	370,442	61,605	0	1,608,904		9.00
10.00	01000 DIETARY	415,323	345,197	0	27,653	2,107,614	10.00
11.00	01100 CAFETERIA	0	0	0	22,122	1,665,506	11.00
13.00	01300 NURSING ADMINISTRATION	463,307	51,439	0	38,714	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	195,534	203,924	0	1,975	0	14.00
15.00	01500 PHARMACY	412,393	52,748	0	16,592	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	781,516	164,396	0	22,122	0	16.00
17.00	01700 SOCIAL SERVICE	79,875	19,415	0	1,975	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	1,069,449	753,221	81,057	508,810	209,975	30.00
31.00	03100 INTENSIVE CARE UNIT	316,753	83,638	8,939	55,306	16,858	31.00
40.00	04000 SUBPROVIDER - IPF	889,326	297,902	9,970	44,244	205,686	40.00
43.00	04300 NURSERY	79,556	0	450	11,061	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,193,799	301,044	13,627	102,710	0	50.00
51.00	05100 RECOVERY ROOM	75,714	32,286	2,491	16,592	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	153,204	0	0	16,592	0	52.00
53.00	05300 ANESTHESIOLOGY	302,899	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,461,780	293,321	21,076	61,231	0	54.00
58.00	05800 MRI	206,661	91,622	0	22,122	0	58.00
60.00	06000 LABORATORY	928,013	275,171	0	44,244	0	60.00
64.00	06400 INTRAVENOUS THERAPY	184,141	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	273,030	51,701	0	16,592	0	65.00
66.00	06600 PHYSICAL THERAPY	817,471	659,373	45,555	77,428	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	65,362	37,085	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	70,821	20,855	0	3,677	0	68.00
69.00	06900 ELECTROCARDIOLOGY	57,437	0	0	5,531	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	9,791	30,497	0	3,950	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	55,780	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	226,492	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	464,957	0	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	855,595	332,675	16,439	126,321	1,959	75.00
76.00	03160 STRESS TESTING	0	0	0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	574,208	170,548	8,044	107,451	0	76.01
76.97	07697 CARDIAC REHABILITATION	100,729	0	0	5,531	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	835,454	180,103	219,478	132,733	7,630	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100 HOME HEALTH AGENCY	707,635	0	0	44,244	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	131,892	0	0	0	0	116.00
117.00	06950 HOMEMAKER	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	16,008,289	4,550,691	427,126	1,537,523	2,107,614	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	158,654	0	0	71,381	0	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	16,166,943	4,550,691	427,126	1,608,904	2,107,614	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:140110

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

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA	1,687,628					11.00
13.00	01300 NURSING ADMINISTRATION	59,997	2,085,337				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	36,074	0	1,058,701			14.00
15.00	01500 PHARMACY	53,087	0	0	1,844,951		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	148,395	345,953	0	0	3,945,183	16.00
17.00	01700 SOCIAL SERVICE	14,678	0	0	0	965	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	208,391	485,898	15,587	0	294,320	30.00
31.00	03100 INTENSIVE CARE UNIT	48,417	112,843	23,915	0	44,307	31.00
40.00	04000 SUBPROVIDER - IPF	164,979	384,609	0	0	395,097	40.00
43.00	04300 NURSERY	12,724	0	0	0	36,295	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	60,997	142,188	0	0	35,716	50.00
51.00	05100 RECOVERY ROOM	11,008	25,671	0	0	10,715	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	25,686	59,893	0	0	1,641	52.00
53.00	05300 ANESTHESIOLOGY	28,593	0	926	0	10,908	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	158,784	0	0	0	1,086,638	54.00
58.00	05800 MRI	12,009	0	0	0	0	58.00
60.00	06000 LABORATORY	89,113	0	1,937	0	40,543	60.00
64.00	06400 INTRAVENOUS THERAPY	23,732	0	26,694	0	1,931	64.00
65.00	06500 RESPIRATORY THERAPY	43,032	0	0	0	772	65.00
66.00	06600 PHYSICAL THERAPY	149,110	0	0	0	74,425	66.00
67.00	06700 OCCUPATIONAL THERAPY	4,480	0	0	0	17,955	67.00
68.00	06800 SPEECH PATHOLOGY	6,052	0	0	0	35,813	68.00
69.00	06900 ELECTROCARDIOLOGY	11,151	0	0	0	120,180	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	143	0	0	0	676	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	831,315	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	157,560	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	1,844,951	2,896	73.00
75.00	07500 ASC (NON-DISTINCT PART)	107,556	250,753	152	0	570,975	75.00
76.00	03160 STRESS TESTING	0	0	0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	82,013	0	0	0	795,697	76.01
76.97	07697 CARDIAC REHABILITATION	7,482	0	0	0	3,668	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	119,040	277,529	615	0	363,050	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	0	0	0	0	0	116.00
117.00	06950 HOMEMAKER	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,686,723	2,085,337	1,058,701	1,844,951	3,945,183	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	905	0	0	0	0	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,687,628	2,085,337	1,058,701	1,844,951	3,945,183	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:140110

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

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Part I  
Date/Time Prepared:  
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Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		17.00	19.00	23.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600						16.00
17.00	01700	370,664					17.00
19.00	01900	0	0				19.00
23.00	02300	0	0	0			23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	344,311	0	0	7,368,554	0	30.00
31.00	03100	20,395	0	0	1,737,664	0	31.00
40.00	04000	0	0	0	5,217,114	0	40.00
43.00	04300	0	0	0	392,827	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	5,642,663	0	50.00
51.00	05100	0	0	0	415,014	0	51.00
52.00	05200	0	0	0	743,729	0	52.00
53.00	05300	0	0	0	1,305,607	0	53.00
54.00	05400	0	0	0	7,726,839	0	54.00
58.00	05800	0	0	0	988,956	0	58.00
60.00	06000	0	0	0	4,327,227	0	60.00
64.00	06400	0	0	0	821,496	0	64.00
65.00	06500	0	0	0	1,252,518	0	65.00
66.00	06600	0	0	0	4,420,389	0	66.00
67.00	06700	0	0	0	332,531	0	67.00
68.00	06800	0	0	0	362,209	0	68.00
69.00	06900	0	0	0	376,771	0	69.00
70.00	07000	0	0	0	76,162	0	70.00
71.00	07100	0	0	0	1,064,304	0	71.00
72.00	07200	0	0	0	1,103,595	0	72.00
73.00	07300	0	0	0	3,789,928	0	73.00
75.00	07500	3,781	0	0	4,984,349	0	75.00
76.00	03160	0	0	0	0	0	76.00
76.01	03550	0	0	0	3,562,164	0	76.01
76.97	07697	0	0	0	437,415	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	2,177	0	0	4,791,965	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	0	0	0	2,999,965	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
116.00	11600	0	0	0	550,901	0	116.00
117.00	06950	0	0	0	0	0	117.00
118.00		370,664	0	0	66,792,856	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	734,968	0	192.00
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		370,664	0	0	67,527,824	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:140110

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)		23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS	7,368,554	30.00
31.00	03100 INTENSIVE CARE UNIT	1,737,664	31.00
40.00	04000 SUBPROVIDER - IPF	5,217,114	40.00
43.00	04300 NURSERY	392,827	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	5,642,663	50.00
51.00	05100 RECOVERY ROOM	415,014	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	743,729	52.00
53.00	05300 ANESTHESIOLOGY	1,305,607	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	7,726,839	54.00
58.00	05800 MRI	988,956	58.00
60.00	06000 LABORATORY	4,327,227	60.00
64.00	06400 INTRAVENOUS THERAPY	821,496	64.00
65.00	06500 RESPIRATORY THERAPY	1,252,518	65.00
66.00	06600 PHYSICAL THERAPY	4,420,389	66.00
67.00	06700 OCCUPATIONAL THERAPY	332,531	67.00
68.00	06800 SPEECH PATHOLOGY	362,209	68.00
69.00	06900 ELECTROCARDIOLOGY	376,771	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	76,162	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,064,304	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,103,595	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,789,928	73.00
75.00	07500 ASC (NON-DISTINCT PART)	4,984,349	75.00
76.00	03160 STRESS TESTING	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,562,164	76.01
76.97	07697 CARDIAC REHABILITATION	437,415	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>			
91.00	09100 EMERGENCY	4,791,965	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
101.00	10100 HOME HEALTH AGENCY	2,999,965	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300 INTEREST EXPENSE		113.00
116.00	11600 HOSPICE	550,901	116.00
117.00	06950 HOMEMAKER	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	66,792,856	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	734,968	192.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	67,527,824	202.00

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	5	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	4	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	5	HOURS OF SERVICE	9.00
10.00	DIETARY	6	MEALS SERVED	10.00
11.00	CAFETERIA	7	FTEs SERVED	11.00
13.00	NURSING ADMINISTRATION	8	HOURS SUPPLEMENTED	13.00
14.00	CENTRAL SERVICES & SUPPLY	9	COSTED REQUIS.	14.00
15.00	PHARMACY	10	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	11	TIME SPENT	16.00
17.00	SOCIAL SERVICE	12	TIME SPENT	17.00
19.00	NONPHYSICIAN ANESTHETISTS	13	ASSIGNED TIME	19.00
23.00	PARAMEDICAL PRGM-(SPECIFY)	14	ASSIGNED TIME	23.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140110

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	634	11,869	11,869	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	125,444	600,698	726,142	5.00
7.00 00700	OPERATION OF PLANT	0	712,468	54,077	766,545	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	9,494	0	9,494	8.00
9.00 00900	HOUSEKEEPING	0	14,291	3,874	18,165	9.00
10.00 01000	DIETARY	0	80,080	9,068	89,148	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	11,933	8,796	20,729	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	47,307	132,396	179,703	14.00
15.00 01500	PHARMACY	0	12,237	65,402	77,639	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	38,137	64,470	102,607	16.00
17.00 01700	SOCIAL SERVICE	0	4,504	157	4,661	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	174,734	85,839	260,573	30.00
31.00 03100	INTENSIVE CARE UNIT	0	19,403	12,546	31,949	31.00
40.00 04000	SUBPROVIDER - IPF	0	69,108	153,773	222,881	40.00
43.00 04300	NURSERY	0	0	1,077	1,077	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	69,837	275,375	345,212	50.00
51.00 05100	RECOVERY ROOM	0	7,490	3,697	11,187	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	19,727	19,727	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	68,046	910,093	978,139	54.00
58.00 05800	MRI	0	21,255	249,414	270,669	58.00
60.00 06000	LABORATORY	0	63,835	35,598	99,433	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	11,994	25,164	37,158	65.00
66.00 06600	PHYSICAL THERAPY	0	152,963	56,256	209,219	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	8,603	0	8,603	67.00
68.00 06800	SPEECH PATHOLOGY	0	4,838	10,107	14,945	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	7,075	15,896	22,971	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	77,175	175,090	252,265	75.00
76.00 03160	STRESS TESTING	0	0	0	0	76.00
76.01 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	39,564	289,618	329,182	76.01
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	0	41,781	80,022	121,803	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100	HOME HEALTH AGENCY	0	0	68,455	68,455	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	0	0	1,005	1,005	116.00
117.00 06950	HOMEMAKER	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,904,831	3,408,324	5,313,155	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	775,118	775,118	192.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers				0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,904,831	4,183,442	6,088,273	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140110

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	727,838					5.00
7.00	00700	49,049	815,961				7.00
8.00	00800	4,163	7,338	21,011			8.00
9.00	00900	16,677	11,046	0	46,186		9.00
10.00	01000	18,698	61,895	0	794	170,808	10.00
11.00	01100	0	0	0	635	134,979	11.00
13.00	01300	20,858	9,223	0	1,111	0	13.00
14.00	01400	8,803	36,565	0	57	0	14.00
15.00	01500	18,566	9,458	0	476	0	15.00
16.00	01600	35,184	29,477	0	635	0	16.00
17.00	01700	3,596	3,481	0	57	0	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	48,146	135,057	3,987	14,606	17,017	30.00
31.00	03100	14,260	14,997	440	1,588	1,366	31.00
40.00	04000	40,037	53,415	490	1,270	16,669	40.00
43.00	04300	3,582	0	22	318	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	53,745	53,979	670	2,948	0	50.00
51.00	05100	3,409	5,789	123	476	0	51.00
52.00	05200	6,897	0	0	476	0	52.00
53.00	05300	13,636	0	0	0	0	53.00
54.00	05400	65,811	52,594	1,037	1,758	0	54.00
58.00	05800	9,304	16,428	0	635	0	58.00
60.00	06000	41,779	49,340	0	1,270	0	60.00
64.00	06400	8,290	0	0	0	0	64.00
65.00	06500	12,292	9,270	0	476	0	65.00
66.00	06600	36,802	118,229	2,241	2,223	0	66.00
67.00	06700	2,943	6,650	0	0	0	67.00
68.00	06800	3,188	3,739	0	106	0	68.00
69.00	06900	2,586	0	0	159	0	69.00
70.00	07000	441	5,468	0	113	0	70.00
71.00	07100	2,511	0	0	0	0	71.00
72.00	07200	10,197	0	0	0	0	72.00
73.00	07300	20,932	0	0	0	0	73.00
75.00	07500	38,519	59,650	809	3,626	159	75.00
76.00	03160	0	0	0	0	0	76.00
76.01	03550	25,851	30,580	396	3,085	0	76.01
76.97	07697	4,535	0	0	159	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	37,612	32,293	10,796	3,810	618	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	31,858	0	0	1,270	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
116.00	11600	5,938	0	0	0	0	116.00
117.00	06950	0	0	0	0	0	117.00
118.00		720,695	815,961	21,011	44,137	170,808	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	7,143	0	0	2,049	0	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		727,838	815,961	21,011	46,186	170,808	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:140110

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	135,614	57,145				13.00
14.00	01400	2,899	0	228,112			14.00
15.00	01500	4,266	0	0	110,736		15.00
16.00	01600	11,925	9,480	0	0	189,876	16.00
17.00	01700	1,179	0	0	0	46	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	16,746	13,317	3,358	0	14,165	30.00
31.00	03100	3,891	3,092	5,153	0	2,132	31.00
40.00	04000	13,257	10,540	0	0	19,015	40.00
43.00	04300	1,022	0	0	0	1,747	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	4,902	3,896	0	0	1,719	50.00
51.00	05100	885	703	0	0	516	51.00
52.00	05200	2,064	1,641	0	0	79	52.00
53.00	05300	2,298	0	200	0	525	53.00
54.00	05400	12,760	0	0	0	52,299	54.00
58.00	05800	965	0	0	0	0	58.00
60.00	06000	7,161	0	417	0	1,951	60.00
64.00	06400	1,907	0	5,752	0	93	64.00
65.00	06500	3,458	0	0	0	37	65.00
66.00	06600	11,982	0	0	0	3,582	66.00
67.00	06700	360	0	0	0	864	67.00
68.00	06800	486	0	0	0	1,724	68.00
69.00	06900	896	0	0	0	5,784	69.00
70.00	07000	11	0	0	0	33	70.00
71.00	07100	0	0	179,119	0	0	71.00
72.00	07200	0	0	33,948	0	0	72.00
73.00	07300	0	0	0	110,736	139	73.00
75.00	07500	8,643	6,871	33	0	27,480	75.00
76.00	03160	0	0	0	0	0	76.00
76.01	03550	6,590	0	0	0	38,296	76.01
76.97	07697	601	0	0	0	177	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	9,566	7,605	132	0	17,473	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
116.00	11600	0	0	0	0	0	116.00
117.00	06950	0	0	0	0	0	117.00
118.00		135,541	57,145	228,112	110,736	189,876	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	73	0	0	0	0	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		135,614	57,145	228,112	110,736	189,876	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:140110

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		17.00	19.00	23.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600						16.00
17.00	01700	13,090					17.00
19.00	01900	0	0				19.00
23.00	02300	0		0			23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	12,159			540,012	0	30.00
31.00	03100	720			79,861	0	31.00
40.00	04000	0			378,306	0	40.00
43.00	04300	0			7,831	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0			467,330	0	50.00
51.00	05100	0			23,154	0	51.00
52.00	05200	0			11,284	0	52.00
53.00	05300	0			37,066	0	53.00
54.00	05400	0			1,165,142	0	54.00
58.00	05800	0			298,070	0	58.00
60.00	06000	0			201,717	0	60.00
64.00	06400	0			16,172	0	64.00
65.00	06500	0			62,897	0	65.00
66.00	06600	0			384,902	0	66.00
67.00	06700	0			19,453	0	67.00
68.00	06800	0			24,216	0	68.00
69.00	06900	0			9,478	0	69.00
70.00	07000	0			29,038	0	70.00
71.00	07100	0			181,630	0	71.00
72.00	07200	0			44,145	0	72.00
73.00	07300	0			131,807	0	73.00
75.00	07500	134			398,802	0	75.00
76.00	03160	0			0	0	76.00
76.01	03550	0			434,673	0	76.01
76.97	07697	0			5,508	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	77			242,235	0	91.00
92.00	09200					0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	0			102,140	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
116.00	11600	0			7,019	0	116.00
117.00	06950	0			0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)		13,090	0	0	5,303,888	0
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0			0	0	190.00
192.00	19200	0			784,385	0	192.00
200.00	Cross Foot Adjustments		0	0	0	0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)		13,090	0	0	6,088,273	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:140110

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)		23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS	540,012	30.00
31.00	03100 INTENSIVE CARE UNIT	79,861	31.00
40.00	04000 SUBPROVIDER - IPF	378,306	40.00
43.00	04300 NURSERY	7,831	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	467,330	50.00
51.00	05100 RECOVERY ROOM	23,154	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	11,284	52.00
53.00	05300 ANESTHESIOLOGY	37,066	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,165,142	54.00
58.00	05800 MRI	298,070	58.00
60.00	06000 LABORATORY	201,717	60.00
64.00	06400 INTRAVENOUS THERAPY	16,172	64.00
65.00	06500 RESPIRATORY THERAPY	62,897	65.00
66.00	06600 PHYSICAL THERAPY	384,902	66.00
67.00	06700 OCCUPATIONAL THERAPY	19,453	67.00
68.00	06800 SPEECH PATHOLOGY	24,216	68.00
69.00	06900 ELECTROCARDIOLOGY	9,478	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	29,038	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	181,630	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	44,145	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	131,807	73.00
75.00	07500 ASC (NON-DISTINCT PART)	398,802	75.00
76.00	03160 STRESS TESTING	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	434,673	76.01
76.97	07697 CARDIAC REHABILITATION	5,508	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>			
91.00	09100 EMERGENCY	242,235	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
101.00	10100 HOME HEALTH AGENCY	102,140	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300 INTEREST EXPENSE		113.00
116.00	11600 HOSPICE	7,019	116.00
117.00	06950 HOMEMAKER	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,303,888	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	784,385	192.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	6,088,273	202.00

Cost Center Description	CAPITAL RELATED COSTS			Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQ. FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)			
	1.00	2.00	4.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	188,200				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		4,160,940			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,110	631	30,365,751		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	12,394	597,467	4,351,528	-16,166,943	5.00
7.00 00700	OPERATION OF PLANT	70,393	53,786	937,660	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	938	0	40,868	0	8.00
9.00 00900	HOUSEKEEPING	1,412	3,853	763,122	0	9.00
10.00 01000	DIETARY	7,912	9,019	698,862	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,179	8,749	1,031,164	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	4,674	131,684	217,538	0	14.00
15.00 01500	PHARMACY	1,209	65,050	845,507	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,768	64,123	1,451,500	0	16.00
17.00 01700	SOCIAL SERVICE	445	156	179,485	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	17,264	85,377	2,252,764	0	30.00
31.00 03100	INTENSIVE CARE UNIT	1,917	12,479	697,749	0	31.00
40.00 04000	SUBPROVIDER - IPF	6,828	152,946	1,871,906	0	40.00
43.00 04300	NURSERY	0	1,071	162,356	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	6,900	273,894	661,366	0	50.00
51.00 05100	RECOVERY ROOM	740	3,677	167,701	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	325,912	0	52.00
53.00 05300	ANESTHESIOLOGY	0	19,621	1,738,272	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	6,723	905,197	1,901,642	0	54.00
58.00 05800	MRI	2,100	248,072	175,269	0	58.00
60.00 06000	LABORATORY	6,307	35,407	935,271	0	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	333,693	0	64.00
65.00 06500	RESPIRATORY THERAPY	1,185	25,029	527,879	0	65.00
66.00 06600	PHYSICAL THERAPY	15,113	55,953	1,596,213	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	850	0	85,347	0	67.00
68.00 06800	SPEECH PATHOLOGY	478	10,053	72,536	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	136,267	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	699	15,810	1,877	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00 07500	ASC (NON-DISTINCT PART)	7,625	174,148	1,566,729	0	75.00
76.00 03160	STRESS TESTING	0	0	0	0	76.00
76.01 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,909	288,060	1,772,822	0	76.01
76.97 07697	CARDIAC REHABILITATION	0	0	91,256	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	4,128	79,592	1,150,632	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100	HOME HEALTH AGENCY	0	68,087	1,423,493	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	0	1,000	193,994	0	116.00
117.00 06950	HOMEMAKER	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	188,200	3,389,991	30,360,180	-16,166,943	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	770,949	5,571	0	192.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per wkst. B, Part I)	1,904,831	4,183,442	10,296,344		202.00
203.00	Unit cost multiplier (wkst. B, Part I)	10.121312	1.005408	0.339078		203.00
204.00	Cost to be allocated (per wkst. B, Part II)			11,869		204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.000391		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:140110

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

Worksheet B-1

Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description		OPERATION OF PLANT (SQARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700	104,303					7.00
8.00	00800	938	848,288				8.00
9.00	00900	1,412	0	52,946			9.00
10.00	01000	7,912	0	910	204,413		10.00
11.00	01100	0	0	728	161,534	35,414	11.00
13.00	01300	1,179	0	1,274	0	1,259	13.00
14.00	01400	4,674	0	65	0	757	14.00
15.00	01500	1,209	0	546	0	1,114	15.00
16.00	01600	3,768	0	728	0	3,114	16.00
17.00	01700	445	0	65	0	308	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	17,264	160,982	16,744	20,365	4,373	30.00
31.00	03100	1,917	17,754	1,820	1,635	1,016	31.00
40.00	04000	6,828	19,800	1,456	19,949	3,462	40.00
43.00	04300	0	893	364	0	267	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	6,900	27,064	3,380	0	1,280	50.00
51.00	05100	740	4,948	546	0	231	51.00
52.00	05200	0	0	546	0	539	52.00
53.00	05300	0	0	0	0	600	53.00
54.00	05400	6,723	41,857	2,015	0	3,332	54.00
58.00	05800	2,100	0	728	0	252	58.00
60.00	06000	6,307	0	1,456	0	1,870	60.00
64.00	06400	0	0	0	0	498	64.00
65.00	06500	1,185	0	546	0	903	65.00
66.00	06600	15,113	90,473	2,548	0	3,129	66.00
67.00	06700	850	0	0	0	94	67.00
68.00	06800	478	0	121	0	127	68.00
69.00	06900	0	0	182	0	234	69.00
70.00	07000	699	0	130	0	3	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
75.00	07500	7,625	32,649	4,157	190	2,257	75.00
76.00	03160	0	0	0	0	0	76.00
76.01	03550	3,909	15,976	3,536	0	1,721	76.01
76.97	07697	0	0	182	0	157	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	4,128	435,892	4,368	740	2,498	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	0	0	1,456	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
116.00	11600	0	0	0	0	0	116.00
117.00	06950	0	0	0	0	0	117.00
118.00		104,303	848,288	50,597	204,413	35,395	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	2,349	0	19	192.00
200.00							200.00
201.00							201.00
202.00		4,550,691	427,126	1,608,904	2,107,614	1,687,628	202.00
203.00		43.629531	0.503515	30.387640	10.310567	47.654261	203.00
204.00		815,961	21,011	46,186	170,808	135,614	204.00
205.00		7.822987	0.024769	0.872323	0.835602	3.829390	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:140110

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

Worksheet B-1

Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description		NURSING ADMINISTRATIO N (HOURS SUPE RVISED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	390,409					13.00
14.00	01400	0	125,726				14.00
15.00	01500	0	0	100			15.00
16.00	01600	64,768	0	0	40,870		16.00
17.00	01700	0	0	0	10	3,235	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	90,968	1,851	0	3,049	3,005	30.00
31.00	03100	21,126	2,840	0	459	178	31.00
40.00	04000	72,005	0	0	4,093	0	40.00
43.00	04300	0	0	0	376	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	26,620	0	0	370	0	50.00
51.00	05100	4,806	0	0	111	0	51.00
52.00	05200	11,213	0	0	17	0	52.00
53.00	05300	0	110	0	113	0	53.00
54.00	05400	0	0	0	11,257	0	54.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	230	0	420	0	60.00
64.00	06400	0	3,170	0	20	0	64.00
65.00	06500	0	0	0	8	0	65.00
66.00	06600	0	0	0	771	0	66.00
67.00	06700	0	0	0	186	0	67.00
68.00	06800	0	0	0	371	0	68.00
69.00	06900	0	0	0	1,245	0	69.00
70.00	07000	0	0	0	7	0	70.00
71.00	07100	0	98,723	0	0	0	71.00
72.00	07200	0	18,711	0	0	0	72.00
73.00	07300	0	0	100	30	0	73.00
75.00	07500	46,945	18	0	5,915	33	75.00
76.00	03160	0	0	0	0	0	76.00
76.01	03550	0	0	0	8,243	0	76.01
76.97	07697	0	0	0	38	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	51,958	73	0	3,761	19	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
116.00	11600	0	0	0	0	0	116.00
117.00	06950	0	0	0	0	0	117.00
118.00		390,409	125,726	100	40,870	3,235	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00							201.00
202.00		2,085,337	1,058,701	1,844,951	3,945,183	370,664	202.00
203.00		5.341416	8.420701	18,449.510000	96.530046	114.579289	203.00
204.00		57,145	228,112	110,736	189,876	13,090	204.00
205.00		0.146372	1.814358	1,107.360000	4.645853	4.046368	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140110

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

Worksheet B-1

Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)	
		19.00	23.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100 CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500 ADMINISTRATIVE & GENERAL			5.00
7.00	00700 OPERATION OF PLANT			7.00
8.00	00800 LAUNDRY & LINEN SERVICE			8.00
9.00	00900 HOUSEKEEPING			9.00
10.00	01000 DIETARY			10.00
11.00	01100 CAFETERIA			11.00
13.00	01300 NURSING ADMINISTRATION			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY			14.00
15.00	01500 PHARMACY			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY			16.00
17.00	01700 SOCIAL SERVICE			17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0		19.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)		0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
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
43.00	04300 NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
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
58.00	05800 MRI	0	0	58.00
60.00	06000 LABORATORY	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
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 PATIENT	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
75.00	07500 ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03160 STRESS TESTING	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00	10100 HOME HEALTH AGENCY	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE	0	0	116.00
117.00	06950 HOMEMAKER	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00	Cross Foot Adjustments			200.00
201.00	Negative Cost Centers			201.00
202.00	Cost to be allocated (per wkst. B, Part I)	0	0	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	0.000000	0.000000	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	0	0	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.000000	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140110

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

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	7,368,554		7,368,554	0	7,368,554	30.00
31.00	03100 INTENSIVE CARE UNIT	1,737,664		1,737,664	0	1,737,664	31.00
40.00	04000 SUBPROVIDER - IPF	5,217,114		5,217,114	0	5,217,114	40.00
43.00	04300 NURSERY	392,827		392,827	0	392,827	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	5,642,663		5,642,663	0	5,642,663	50.00
51.00	05100 RECOVERY ROOM	415,014		415,014	0	415,014	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	743,729		743,729	0	743,729	52.00
53.00	05300 ANESTHESIOLOGY	1,305,607		1,305,607	77,808	1,383,415	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	7,726,839		7,726,839	0	7,726,839	54.00
58.00	05800 MRI	988,956		988,956	0	988,956	58.00
60.00	06000 LABORATORY	4,327,227		4,327,227	0	4,327,227	60.00
64.00	06400 INTRAVENOUS THERAPY	821,496		821,496	0	821,496	64.00
65.00	06500 RESPIRATORY THERAPY	1,252,518	0	1,252,518	0	1,252,518	65.00
66.00	06600 PHYSICAL THERAPY	4,420,389	0	4,420,389	0	4,420,389	66.00
67.00	06700 OCCUPATIONAL THERAPY	332,531	0	332,531	0	332,531	67.00
68.00	06800 SPEECH PATHOLOGY	362,209	0	362,209	0	362,209	68.00
69.00	06900 ELECTROCARDIOLOGY	376,771		376,771	0	376,771	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	76,162		76,162	0	76,162	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,064,304		1,064,304	0	1,064,304	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,103,595		1,103,595	0	1,103,595	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,789,928		3,789,928	0	3,789,928	73.00
75.00	07500 ASC (NON-DISTINCT PART)	4,984,349		4,984,349	0	4,984,349	75.00
76.00	03160 STRESS TESTING	0		0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,562,164		3,562,164	26,821	3,588,985	76.01
76.97	07697 CARDIAC REHABILITATION	437,415		437,415	0	437,415	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	4,791,965		4,791,965	143,239	4,935,204	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	932,763		932,763		932,763	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100 HOME HEALTH AGENCY	2,999,965		2,999,965		2,999,965	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	550,901		550,901		550,901	116.00
117.00	06950 HOMEMAKER	0		0		0	117.00
200.00	Subtotal (see instructions)	67,725,619	0	67,725,619	247,868	67,973,487	200.00
201.00	Less Observation Beds	932,763		932,763		932,763	201.00
202.00	Total (see instructions)	66,792,856	0	66,792,856	247,868	67,040,724	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140110

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

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

		Title XVIII			Hospital	PPS
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	8,773,634		8,773,634	30.00
31.00	03100	INTENSIVE CARE UNIT	1,966,748		1,966,748	31.00
40.00	04000	SUBPROVIDER - IPF	9,315,536		9,315,536	40.00
43.00	04300	NURSERY	603,104		603,104	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	4,685,596	14,757,816	19,443,412	0.290210 50.00
51.00	05100	RECOVERY ROOM	388,468	1,814,692	2,203,160	0.188372 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,120,439	247,770	1,368,209	0.543579 52.00
53.00	05300	ANESTHESIOLOGY	975,031	5,239,809	6,214,840	0.210079 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,378,048	30,935,287	36,313,335	0.212782 54.00
58.00	05800	MRI	265,299	4,354,644	4,619,943	0.214062 58.00
60.00	06000	LABORATORY	7,517,542	15,359,215	22,876,757	0.189154 60.00
64.00	06400	INTRAVENOUS THERAPY	1,132,870	501,890	1,634,760	0.502518 64.00
65.00	06500	RESPIRATORY THERAPY	4,887,976	1,836,649	6,724,625	0.186258 65.00
66.00	06600	PHYSICAL THERAPY	647,111	6,420,119	7,067,230	0.625477 66.00
67.00	06700	OCCUPATIONAL THERAPY	58,440	537,602	596,042	0.557899 67.00
68.00	06800	SPEECH PATHOLOGY	4,674	368,575	373,249	0.970422 68.00
69.00	06900	ELECTROCARDIOLOGY	792,767	1,195,079	1,987,846	0.189537 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11,889	30,830	42,719	1.782860 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	820,291	846,255	1,666,546	0.638629 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,281,584	1,701,139	2,982,723	0.369996 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,749,230	4,470,151	9,219,381	0.411083 73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,161,030	9,087,500	10,248,530	0.486348 75.00
76.00	03160	STRESS TESTING	0	0	0	0.000000 76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,608	2,370,163	2,373,771	1.500635 76.01
76.97	07697	CARDIAC REHABILITATION	510,591	2,007,285	2,517,876	0.173724 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100	EMERGENCY	3,656,520	12,853,956	16,510,476	0.290238 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	189,126	1,960,011	2,149,137	0.434017 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100	HOME HEALTH AGENCY	0	2,857,063	2,857,063	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	2,070,881	2,070,881	116.00
117.00	06950	HOMEMAKER	0	0	0	117.00
200.00		Subtotal (see instructions)	60,897,152	123,824,381	184,721,533	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	60,897,152	123,824,381	184,721,533	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:140110

Period:  
From 10/01/2012  
To 09/30/2013Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.290210			50.00
51.00	05100 RECOVERY ROOM	0.188372			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.543579			52.00
53.00	05300 ANESTHESIOLOGY	0.222599			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.212782			54.00
58.00	05800 MRI	0.214062			58.00
60.00	06000 LABORATORY	0.189154			60.00
64.00	06400 INTRAVENOUS THERAPY	0.502518			64.00
65.00	06500 RESPIRATORY THERAPY	0.186258			65.00
66.00	06600 PHYSICAL THERAPY	0.625477			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.557899			67.00
68.00	06800 SPEECH PATHOLOGY	0.970422			68.00
69.00	06900 ELECTROCARDIOLOGY	0.189537			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.782860			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.638629			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.369996			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.411083			73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.486348			75.00
76.00	03160 STRESS TESTING	0.000000			76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.511934			76.01
76.97	07697 CARDIAC REHABILITATION	0.173724			76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100 EMERGENCY	0.298913			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.434017			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100 HOME HEALTH AGENCY				101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300 INTEREST EXPENSE				113.00
116.00	11600 HOSPICE				116.00
117.00	06950 HOMEMAKER				117.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140110

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

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Hospital		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	7,368,554		7,368,554	0	7,368,554	30.00
31.00	03100 INTENSIVE CARE UNIT	1,737,664		1,737,664	0	1,737,664	31.00
40.00	04000 SUBPROVIDER - IPF	5,217,114		5,217,114	0	5,217,114	40.00
43.00	04300 NURSERY	392,827		392,827	0	392,827	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	5,642,663		5,642,663	0	5,642,663	50.00
51.00	05100 RECOVERY ROOM	415,014		415,014	0	415,014	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	743,729		743,729	0	743,729	52.00
53.00	05300 ANESTHESIOLOGY	1,305,607		1,305,607	77,808	1,383,415	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	7,726,839		7,726,839	0	7,726,839	54.00
58.00	05800 MRI	988,956		988,956	0	988,956	58.00
60.00	06000 LABORATORY	4,327,227		4,327,227	0	4,327,227	60.00
64.00	06400 INTRAVENOUS THERAPY	821,496		821,496	0	821,496	64.00
65.00	06500 RESPIRATORY THERAPY	1,252,518	0	1,252,518	0	1,252,518	65.00
66.00	06600 PHYSICAL THERAPY	4,420,389	0	4,420,389	0	4,420,389	66.00
67.00	06700 OCCUPATIONAL THERAPY	332,531	0	332,531	0	332,531	67.00
68.00	06800 SPEECH PATHOLOGY	362,209	0	362,209	0	362,209	68.00
69.00	06900 ELECTROCARDIOLOGY	376,771		376,771	0	376,771	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	76,162		76,162	0	76,162	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,064,304		1,064,304	0	1,064,304	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,103,595		1,103,595	0	1,103,595	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,789,928		3,789,928	0	3,789,928	73.00
75.00	07500 ASC (NON-DISTINCT PART)	4,984,349		4,984,349	0	4,984,349	75.00
76.00	03160 STRESS TESTING	0		0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,562,164		3,562,164	26,821	3,588,985	76.01
76.97	07697 CARDIAC REHABILITATION	437,415		437,415	0	437,415	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	4,791,965		4,791,965	143,239	4,935,204	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	932,763		932,763		932,763	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100 HOME HEALTH AGENCY	2,999,965		2,999,965		2,999,965	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	550,901		550,901		550,901	116.00
117.00	06950 HOMEMAKER	0		0		0	117.00
200.00	Subtotal (see instructions)	67,725,619	0	67,725,619	247,868	67,973,487	200.00
201.00	Less Observation Beds	932,763		932,763		932,763	201.00
202.00	Total (see instructions)	66,792,856	0	66,792,856	247,868	67,040,724	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:140110

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

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	8,773,634		8,773,634			30.00
31.00 03100 INTENSIVE CARE UNIT	1,966,748		1,966,748			31.00
40.00 04000 SUBPROVIDER - IPF	9,315,536		9,315,536			40.00
43.00 04300 NURSERY	603,104		603,104			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	4,685,596	14,757,816	19,443,412	0.290210	0.000000	50.00
51.00 05100 RECOVERY ROOM	388,468	1,814,692	2,203,160	0.188372	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1,120,439	247,770	1,368,209	0.543579	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	975,031	5,239,809	6,214,840	0.210079	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	5,378,048	30,935,287	36,313,335	0.212782	0.000000	54.00
58.00 05800 MRI	265,299	4,354,644	4,619,943	0.214062	0.000000	58.00
60.00 06000 LABORATORY	7,517,542	15,359,215	22,876,757	0.189154	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	1,132,870	501,890	1,634,760	0.502518	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	4,887,976	1,836,649	6,724,625	0.186258	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	647,111	6,420,119	7,067,230	0.625477	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	58,440	537,602	596,042	0.557899	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	4,674	368,575	373,249	0.970422	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	792,767	1,195,079	1,987,846	0.189537	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	11,889	30,830	42,719	1.782860	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	820,291	846,255	1,666,546	0.638629	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1,281,584	1,701,139	2,982,723	0.369996	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4,749,230	4,470,151	9,219,381	0.411083	0.000000	73.00
75.00 07500 ASC (NON-DISTINCT PART)	1,161,030	9,087,500	10,248,530	0.486348	0.000000	75.00
76.00 03160 STRESS TESTING	0	0	0	0.000000	0.000000	76.00
76.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,608	2,370,163	2,373,771	1.500635	0.000000	76.01
76.97 07697 CARDIAC REHABILITATION	510,591	2,007,285	2,517,876	0.173724	0.000000	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100 EMERGENCY	3,656,520	12,853,956	16,510,476	0.290238	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	189,126	1,960,011	2,149,137	0.434017	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100 HOME HEALTH AGENCY	0	2,857,063	2,857,063			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPICE	0	2,070,881	2,070,881			116.00
117.00 06950 HOMEMAKER	0	0	0			117.00
200.00	Subtotal (see instructions)	60,897,152	123,824,381	184,721,533		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	60,897,152	123,824,381	184,721,533		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:140110

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

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
58.00	05800 MRI	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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
75.00	07500 ASC (NON-DISTINCT PART)	0.000000			75.00
76.00	03160 STRESS TESTING	0.000000			76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.01
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100 HOME HEALTH AGENCY				101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300 INTEREST EXPENSE				113.00
116.00	11600 HOSPICE				116.00
117.00	06950 HOMEMAKER				117.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140110

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

Worksheet D  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description	Title XVIII			Hospital	PPS	
	Capital Related Cost (from wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	540,012	0	540,012	7,086	76.21	30.00
31.00 INTENSIVE CARE UNIT	79,861		79,861	828	96.45	31.00
40.00 SUBPROVIDER - IPF	378,306	0	378,306	5,052	74.88	40.00
43.00 NURSERY	7,831		7,831	603	12.99	43.00
200.00 Total (lines 30-199)	1,006,010		1,006,010	13,569		200.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
	6.00	7.00				
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	3,368	256,675				
31.00 INTENSIVE CARE UNIT	526	50,733				
40.00 SUBPROVIDER - IPF	1,660	124,301				
43.00 NURSERY	0	0				
200.00 Total (lines 30-199)	5,554	431,709				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN:140110

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

Worksheet D  
Part II  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description	Title XVIII			Hospital	PPS	
	Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	467,330	19,443,412	0.024035	2,240,416	53,848 50.00
51.00	05100 RECOVERY ROOM	23,154	2,203,160	0.010509	188,093	1,977 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	11,284	1,368,209	0.008247	0	0 52.00
53.00	05300 ANESTHESIOLOGY	37,066	6,214,840	0.005964	550,917	3,286 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,165,142	36,313,335	0.032086	3,039,958	97,540 54.00
58.00	05800 MRI	298,070	4,619,943	0.064518	187,398	12,091 58.00
60.00	06000 LABORATORY	201,717	22,876,757	0.008818	3,667,366	32,339 60.00
64.00	06400 INTRAVENOUS THERAPY	16,172	1,634,760	0.009893	661,072	6,540 64.00
65.00	06500 RESPIRATORY THERAPY	62,897	6,724,625	0.009353	3,351,271	31,344 65.00
66.00	06600 PHYSICAL THERAPY	384,902	7,067,230	0.054463	490,172	26,696 66.00
67.00	06700 OCCUPATIONAL THERAPY	19,453	596,042	0.032637	42,302	1,381 67.00
68.00	06800 SPEECH PATHOLOGY	24,216	373,249	0.064879	3,638	236 68.00
69.00	06900 ELECTROCARDIOLOGY	9,478	1,987,846	0.004768	534,142	2,547 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	29,038	42,719	0.679744	4,564	3,102 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	181,630	1,666,546	0.108986	437,181	47,647 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	44,145	2,982,723	0.014800	679,140	10,051 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	131,807	9,219,381	0.014297	2,047,677	29,276 73.00
75.00	07500 ASC (NON-DISTINCT PART)	398,802	10,248,530	0.038913	586,071	22,806 75.00
76.00	03160 STRESS TESTING	0	0	0.000000	0	0 76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	434,673	2,373,771	0.183115	0	0 76.01
76.97	07697 CARDIAC REHABILITATION	5,508	2,517,876	0.002188	280,834	614 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100 EMERGENCY	242,235	16,510,476	0.014672	1,640,032	24,063 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	68,358	2,149,137	0.031807	129,317	4,113 92.00
200.00	Total (lines 50-199)	4,257,077	159,134,567		20,761,561	411,497 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN:140110

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

Worksheet D  
Part III  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description			Title XVIII				Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)			
			1.00	2.00	3.00	4.00	5.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
200.00		Total (lines 30-199)	0	0	0	0	0	0	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			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>										
30.00	03000	ADULTS & PEDIATRICS	7,086	0.00	3,368	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	828	0.00	526	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	5,052	0.00	1,660	0	0	0	40.00	
43.00	04300	NURSERY	603	0.00	0	0	0	0	43.00	
200.00		Total (lines 30-199)	13,569		5,554	0	0	0	200.00	
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost						
			12.00	13.00						
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>										
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	
43.00	04300	NURSERY	0	0					43.00	
200.00		Total (lines 30-199)	0	0					200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:140110

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

Worksheet D  
Part IV  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description	Title XVIII			Hospital	PPS	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0	0	0 50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
58.00	05800 MRI	0	0	0	0	0 58.00
60.00	06000 LABORATORY	0	0	0	0	0 60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
76.00	03160 STRESS TESTING	0	0	0	0	0 76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0 76.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
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)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:140110

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

Worksheet D  
Part IV  
Date/Time Prepared:  
2/27/2014 1:54 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)	Hospital		Inpatient Program Charges	
				Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	PPS		
	6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0	19,443,412	0.000000	0.000000	2,240,416	50.00	
51.00 05100 RECOVERY ROOM	0	2,203,160	0.000000	0.000000	188,093	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1,368,209	0.000000	0.000000	0	52.00	
53.00 05300 ANESTHESIOLOGY	0	6,214,840	0.000000	0.000000	550,917	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	36,313,335	0.000000	0.000000	3,039,958	54.00	
58.00 05800 MRI	0	4,619,943	0.000000	0.000000	187,398	58.00	
60.00 06000 LABORATORY	0	22,876,757	0.000000	0.000000	3,667,366	60.00	
64.00 06400 INTRAVENOUS THERAPY	0	1,634,760	0.000000	0.000000	661,072	64.00	
65.00 06500 RESPIRATORY THERAPY	0	6,724,625	0.000000	0.000000	3,351,271	65.00	
66.00 06600 PHYSICAL THERAPY	0	7,067,230	0.000000	0.000000	490,172	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	596,042	0.000000	0.000000	42,302	67.00	
68.00 06800 SPEECH PATHOLOGY	0	373,249	0.000000	0.000000	3,638	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	1,987,846	0.000000	0.000000	534,142	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	42,719	0.000000	0.000000	4,564	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,666,546	0.000000	0.000000	437,181	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	2,982,723	0.000000	0.000000	679,140	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	9,219,381	0.000000	0.000000	2,047,677	73.00	
75.00 07500 ASC (NON-DISTINCT PART)	0	10,248,530	0.000000	0.000000	586,071	75.00	
76.00 03160 STRESS TESTING	0	0	0.000000	0.000000	0	76.00	
76.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	2,373,771	0.000000	0.000000	0	76.01	
76.97 07697 CARDIAC REHABILITATION	0	2,517,876	0.000000	0.000000	280,834	76.97	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00 09100 EMERGENCY	0	16,510,476	0.000000	0.000000	1,640,032	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,149,137	0.000000	0.000000	129,317	92.00	
200.00 Total (lines 50-199)	0	159,134,567			20,761,561	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:140110

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

Worksheet D  
Part IV  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1		
		11.00	12.00	12.01	13.00	13.01		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000 OPERATING ROOM	0	260,085	2,110,468	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	97,824	494,158	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	898	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	445,300	1,436,447	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	2,806,606	8,230,345	0	0	0	54.00
58.00	05800 MRI	0	368,097	1,020,199	0	0	0	58.00
60.00	06000 LABORATORY	0	174,586	524,016	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	141,354	335,410	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	180,353	497,886	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	110,914	455,236	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	14,345	29,999	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	146,644	391,451	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	4,564	7,234	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	50,003	248,676	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	165,287	573,661	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	388,654	1,564,109	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	2,103,923	5,467,151	0	0	0	75.00
76.00	03160 STRESS TESTING	0	0	0	0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	136,530	382,488	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	223,926	501,817	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100 EMERGENCY	0	712,866	1,987,493	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	127,280	501,695	0	0	0	92.00
200.00	Total (lines 50-199)	0	8,659,141	26,760,837	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:140110

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

Worksheet D  
Part IV  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description	Title XVIII			Hospital		PPS
	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
	21.00	22.00	23.00	24.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
58.00	05800 MRI	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03160 STRESS TESTING	0	0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100 EMERGENCY	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:140110

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

Worksheet D  
Part V  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
			PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			1.00	2.00	2.01	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.290210	260,085	2,110,468	0	0	50.00
51.00	05100 RECOVERY ROOM	0.188372	97,824	494,158	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.543579	0	898	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.210079	445,300	1,436,447	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.212782	2,806,606	8,230,345	57	0	54.00
58.00	05800 MRI	0.214062	368,097	1,020,199	8	0	58.00
60.00	06000 LABORATORY	0.189154	174,586	524,016	2,710	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.502518	141,354	335,410	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.186258	180,353	497,886	514	0	65.00
66.00	06600 PHYSICAL THERAPY	0.625477	110,914	455,236	262	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.557899	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.970422	14,345	29,999	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.189537	146,644	391,451	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.782860	4,564	7,234	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.638629	50,003	248,676	5	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.369996	165,287	573,661	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.411083	388,654	1,564,109	222	13,761	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.486348	2,103,923	5,467,151	7	0	75.00
76.00	03160 STRESS TESTING	0.000000	0	0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.500635	136,530	382,488	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.173724	223,926	501,817	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	0.290238	712,866	1,987,493	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.434017	127,280	501,695	0	0	92.00
200.00	Subtotal (see instructions)		8,659,141	26,760,837	3,785	13,761	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		8,659,141	26,760,837	3,785	13,761	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:140110

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

Worksheet D  
Part V  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description	Costs				Hospital	PPS
	PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	5.00	5.01	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	75,479	612,479	0	0	50.00
51.00	05100 RECOVERY ROOM	18,427	93,086	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	488	0	0	52.00
53.00	05300 ANESTHESIOLOGY	93,548	301,767	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	597,195	1,751,269	12	0	54.00
58.00	05800 MRI	78,796	218,386	2	0	58.00
60.00	06000 LABORATORY	33,024	99,120	513	0	60.00
64.00	06400 INTRAVENOUS THERAPY	71,033	168,550	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	33,592	92,735	96	0	65.00
66.00	06600 PHYSICAL THERAPY	69,374	284,740	164	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	13,921	29,112	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	27,794	74,194	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	8,137	12,897	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	31,933	158,812	3	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	61,156	212,252	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	159,769	642,979	91	5,657	73.00
75.00	07500 ASC (NON-DISTINCT PART)	1,023,239	2,658,938	3	0	75.00
76.00	03160 STRESS TESTING	0	0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	204,882	573,975	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	38,901	87,178	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100 EMERGENCY	206,901	576,846	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	55,242	217,744	0	0	92.00
200.00	Subtotal (see instructions)	2,902,343	8,867,547	884	5,657	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0		201.00
202.00	Net Charges (line 200 +/- line 201)	2,902,343	8,867,547	884	5,657	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN:140110  
Component CCN:14S110

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

Worksheet D  
Part II  
Date/Time Prepared:  
2/27/2014 1:54 pm  
PPS

Title XVIII

Subprovider -  
IPF

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	467,330	19,443,412	0.024035	7,131	171	50.00
51.00	05100 RECOVERY ROOM	23,154	2,203,160	0.010509	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	11,284	1,368,209	0.008247	0	0	52.00
53.00	05300 ANESTHESIOLOGY	37,066	6,214,840	0.005964	440	3	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,165,142	36,313,335	0.032086	66,764	2,142	54.00
58.00	05800 MRI	298,070	4,619,943	0.064518	3,069	198	58.00
60.00	06000 LABORATORY	201,717	22,876,757	0.008818	427,273	3,768	60.00
64.00	06400 INTRAVENOUS THERAPY	16,172	1,634,760	0.009893	120,061	1,188	64.00
65.00	06500 RESPIRATORY THERAPY	62,897	6,724,625	0.009353	123,535	1,155	65.00
66.00	06600 PHYSICAL THERAPY	384,902	7,067,230	0.054463	22,653	1,234	66.00
67.00	06700 OCCUPATIONAL THERAPY	19,453	596,042	0.032637	504	16	67.00
68.00	06800 SPEECH PATHOLOGY	24,216	373,249	0.064879	606	39	68.00
69.00	06900 ELECTROCARDIOLOGY	9,478	1,987,846	0.004768	49,291	235	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	29,038	42,719	0.679744	1,304	886	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	181,630	1,666,546	0.108986	4,028	439	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	44,145	2,982,723	0.014800	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	131,807	9,219,381	0.014297	338,897	4,845	73.00
75.00	07500 ASC (NON-DISTINCT PART)	398,802	10,248,530	0.038913	733	29	75.00
76.00	03160 STRESS TESTING	0	0	0.000000	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	434,673	2,373,771	0.183115	3,608	661	76.01
76.97	07697 CARDIAC REHABILITATION	5,508	2,517,876	0.002188	3,866	8	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	242,235	16,510,476	0.014672	283,109	4,154	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,149,137	0.000000	0	0	92.00
200.00	Total (lines 50-199)	4,188,719	159,134,567		1,456,872	21,171	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:140110  
Component CCN:145110

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

Worksheet D  
Part IV  
Date/Time Prepared:  
2/27/2014 1:54 pm

Title XVIII

Subprovider -  
IPF

PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03160 STRESS TESTING	0	0	0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:140110  
Component CCN:14S110

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

Worksheet D  
Part IV  
Date/Time Prepared:  
2/27/2014 1:54 pm

Title XVIII

Subprovider -  
IPF

PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	19,443,412	0.000000	0.000000	7,131	50.00
51.00	05100 RECOVERY ROOM	0	2,203,160	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,368,209	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	6,214,840	0.000000	0.000000	440	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	36,313,335	0.000000	0.000000	66,764	54.00
58.00	05800 MRI	0	4,619,943	0.000000	0.000000	3,069	58.00
60.00	06000 LABORATORY	0	22,876,757	0.000000	0.000000	427,273	60.00
64.00	06400 INTRAVENOUS THERAPY	0	1,634,760	0.000000	0.000000	120,061	64.00
65.00	06500 RESPIRATORY THERAPY	0	6,724,625	0.000000	0.000000	123,535	65.00
66.00	06600 PHYSICAL THERAPY	0	7,067,230	0.000000	0.000000	22,653	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	596,042	0.000000	0.000000	504	67.00
68.00	06800 SPEECH PATHOLOGY	0	373,249	0.000000	0.000000	606	68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,987,846	0.000000	0.000000	49,291	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	42,719	0.000000	0.000000	1,304	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,666,546	0.000000	0.000000	4,028	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2,982,723	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	9,219,381	0.000000	0.000000	338,897	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	10,248,530	0.000000	0.000000	733	75.00
76.00	03160 STRESS TESTING	0	0	0.000000	0.000000	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	2,373,771	0.000000	0.000000	3,608	76.01
76.97	07697 CARDIAC REHABILITATION	0	2,517,876	0.000000	0.000000	3,866	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	0	16,510,476	0.000000	0.000000	283,109	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,149,137	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	159,134,567			1,456,872	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:140110  
Component CCN:14S110

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

Worksheet D  
Part IV  
Date/Time Prepared:  
2/27/2014 1:54 pm

Title XVIII

Subprovider -  
IPF

PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	
		11.00	12.00	12.01	13.00	13.01	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	291	0	0	54.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	3	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	241	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03160 STRESS TESTING	0	0	0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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)	0	0	535	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:140110  
Component CCN:145110

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

Worksheet D  
Part IV  
Date/Time Prepared:  
2/27/2014 1:54 pm  
PPS

Title XVIII

Subprovider -  
IPF

Cost Center Description		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		21.00	22.00	23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
58.00	05800 MRI	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03160 STRESS TESTING	0	0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100 EMERGENCY	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:140110

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

Worksheet D  
Part V  
Date/Time Prepared:  
2/27/2014 1:54 pm

Component CCN:145110

Title XVIII

Subprovider -  
IPF

PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	1.00	2.00	2.01	3.00	4.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0.290210	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.188372	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.543579	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.210079	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.212782	0	291	0	54.00
58.00	05800 MRI	0.214062	0	0	0	58.00
60.00	06000 LABORATORY	0.189154	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.502518	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.186258	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.625477	0	3	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.557899	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.970422	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.189537	0	241	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.782860	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.638629	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.369996	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.411083	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.486348	0	0	0	75.00
76.00	03160 STRESS TESTING	0.000000	0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.500635	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.173724	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100 EMERGENCY	0.290238	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.434017	0	0	0	92.00
200.00	Subtotal (see instructions)		0	535	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	535	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:140110

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

Worksheet D  
Part V  
Date/Time Prepared:  
2/27/2014 1:54 pm

Component CCN:14S110

Title XVIII

Subprovider -  
IPF

PPS

Cost Center Description	Costs					
	PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	5.00	5.01	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	62	0	0	54.00
58.00	05800 MRI	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	2	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	46	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03160 STRESS TESTING	0	0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100 EMERGENCY	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00	Subtotal (see instructions)	0	110	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	0	110	0	0	202.00

## COMPUTATION OF INPATIENT OPERATING COST

Provider CCN:140110

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

Worksheet D-1

Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description		Title XVIII	Hospital	PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			7,086 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			7,086 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			6,189 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)			3,368 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
<b>SWING BED ADJUSTMENT</b>				
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)			7,368,554 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)			7,368,554 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)			7,368,554 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,039.87 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,502,282 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)			3,502,282 41.00

## COMPUTATION OF INPATIENT OPERATING COST

Provider CCN:140110

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

Worksheet D-1

Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description	Title XVIII			Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	
	0	0	0.00	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>						
43.00 INTENSIVE CARE UNIT	1,737,664	828	2,098.63	526	1,103,879	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
<b>Cost Center Description</b>						
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,840,831	48.00
					10,446,992	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>						
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					307,408	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					411,497	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					718,905	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					9,728,087	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>						
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
87.00 Total observation bed days (see instructions)					897	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,039.87	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					932,763	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140110

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

Worksheet D-1

Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Hospital		
				Total Observation Bed Cost (from line 89)	PPS Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
90.00 Capital-related cost	540,012	7,368,554	0.073286	932,763	68,358	90.00
91.00 Nursing School cost	0	7,368,554	0.000000	932,763	0	91.00
92.00 Allied health cost	0	7,368,554	0.000000	932,763	0	92.00
93.00 All other Medical Education	0	7,368,554	0.000000	932,763	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140110

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

Worksheet D-1

Component CCN: 145110

Date/Time Prepared:  
2/27/2014 1:54 pm

Title XVIII

Subprovider -  
IPF

PPS

Cost Center Description		1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>			
<b>INPATIENT DAYS</b>			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,052	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,052	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)	5,052	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,660	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
<b>SWING BED ADJUSTMENT</b>			
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)	5,217,114	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)	5,217,114	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>			
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)	5,217,114	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>			
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,032.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,714,249	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)	1,714,249	41.00

## COMPUTATION OF INPATIENT OPERATING COST

Provider CCN:140110

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

Worksheet D-1

Component CCN:145110

Date/Time Prepared:  
2/27/2014 1:54 pm

Title XVIII

Subprovider -  
IPF

PPS

Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 + col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>						
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
<b>Cost Center Description</b>						
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					440,892	48.00
<b>PASS THROUGH COST ADJUSTMENTS</b>						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					124,301	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					21,171	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					145,472	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,009,669	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>						
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140110  
Component CCN: 14S110

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

Worksheet D-1  
Date/Time Prepared:  
2/27/2014 1:54 pm  
PPS

Title XVIII

Subprovider -  
IPF

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	
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
90.00 Capital-related cost	378,306	5,217,114	0.072513	0	0	90.00
91.00 Nursing School cost	0	5,217,114	0.000000	0	0	91.00
92.00 Allied health cost	0	5,217,114	0.000000	0	0	92.00
93.00 All other Medical Education	0	5,217,114	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140110

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

Worksheet D-3

Date/Time Prepared:  
2/27/2014 1:54 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT	3,574,216		31.00
40.00	04000	SUBPROVIDER - IPF	1,187,028		40.00
43.00	04300	NURSERY	0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.290210	2,240,416	650,191
51.00	05100	RECOVERY ROOM	0.188372	188,093	35,431
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.543579	0	0
53.00	05300	ANESTHESIOLOGY	0.222599	550,917	122,634
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.212782	3,039,958	646,848
58.00	05800	MRI	0.214062	187,398	40,115
60.00	06000	LABORATORY	0.189154	3,667,366	693,697
64.00	06400	INTRAVENOUS THERAPY	0.502518	661,072	332,201
65.00	06500	RESPIRATORY THERAPY	0.186258	3,351,271	624,201
66.00	06600	PHYSICAL THERAPY	0.625477	490,172	306,591
67.00	06700	OCCUPATIONAL THERAPY	0.557899	42,302	23,600
68.00	06800	SPEECH PATHOLOGY	0.970422	3,638	3,530
69.00	06900	ELECTROCARDIOLOGY	0.189537	534,142	101,240
70.00	07000	ELECTROENCEPHALOGRAPHY	1.782860	4,564	8,137
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.638629	437,181	279,196
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.369996	679,140	251,279
73.00	07300	DRUGS CHARGED TO PATIENTS	0.411083	2,047,677	841,765
75.00	07500	ASC (NON-DISTINCT PART)	0.486348	586,071	285,034
76.00	03160	STRESS TESTING	0.000000	0	0
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.511934	0	0
76.97	07697	CARDIAC REHABILITATION	0.173724	280,834	48,788
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100	EMERGENCY	0.298913	1,640,032	490,227
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.434017	129,317	56,126
200.00		Total (sum of lines 50-94 and 96-98)		20,761,561	5,840,831
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0
202.00		Net Charges (line 200 minus line 201)		20,761,561	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN:140110

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

Worksheet D-3

Component CCN:14S110

Date/Time Prepared:  
2/27/2014 1:54 pm

Title XVIII

Subprovider -  
IPF

PPS

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		2,695,163		40.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.290210	7,131	2,069	50.00
51.00	05100 RECOVERY ROOM	0.188372	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.543579	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.222599	440	98	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.212782	66,764	14,206	54.00
58.00	05800 MRI	0.214062	3,069	657	58.00
60.00	06000 LABORATORY	0.189154	427,273	80,820	60.00
64.00	06400 INTRAVENOUS THERAPY	0.502518	120,061	60,333	64.00
65.00	06500 RESPIRATORY THERAPY	0.186258	123,535	23,009	65.00
66.00	06600 PHYSICAL THERAPY	0.625477	22,653	14,169	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.557899	504	281	67.00
68.00	06800 SPEECH PATHOLOGY	0.970422	606	588	68.00
69.00	06900 ELECTROCARDIOLOGY	0.189537	49,291	9,342	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.782860	1,304	2,325	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.638629	4,028	2,572	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.369996	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.411083	338,897	139,315	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.486348	733	356	75.00
76.00	03160 STRESS TESTING	0.000000	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.511934	3,608	5,455	76.01
76.97	07697 CARDIAC REHABILITATION	0.173724	3,866	672	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100 EMERGENCY	0.298913	283,109	84,625	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.434017	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,456,872	440,892	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)		1,456,872		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140110

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

Worksheet D-3

Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		1,072,732		30.00
31.00	03100 INTENSIVE CARE UNIT		119,240		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
43.00	04300 NURSERY		197,024		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.290210	316,260	91,782	50.00
51.00	05100 RECOVERY ROOM	0.188372	23,180	4,366	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.543579	288,870	157,024	52.00
53.00	05300 ANESTHESIOLOGY	0.210079	132,878	27,915	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.212782	265,843	56,567	54.00
58.00	05800 MRI	0.214062	10,668	2,284	58.00
60.00	06000 LABORATORY	0.189154	488,815	92,461	60.00
64.00	06400 INTRAVENOUS THERAPY	0.502518	143,701	72,212	64.00
65.00	06500 RESPIRATORY THERAPY	0.186258	174,425	32,488	65.00
66.00	06600 PHYSICAL THERAPY	0.625477	15,726	9,836	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.557899	1,755	979	67.00
68.00	06800 SPEECH PATHOLOGY	0.970422	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.189537	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.782860	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.638629	110,764	70,737	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.369996	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.411083	306,227	125,885	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.486348	81,516	39,645	75.00
76.00	03160 STRESS TESTING	0.000000	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.500635	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.173724	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100 EMERGENCY	0.290238	199,382	57,868	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.434017	7,320	3,177	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,567,330	845,226	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		2,567,330		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140110  
Component CCN: 145110

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

Worksheet D-3  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		2,683,342		40.00
43.00	04300 NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.290210	0	0	50.00
51.00	05100 RECOVERY ROOM	0.188372	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.543579	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.210079	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.212782	52,599	11,192	54.00
58.00	05800 MRI	0.214062	5,000	1,070	58.00
60.00	06000 LABORATORY	0.189154	486,352	91,995	60.00
64.00	06400 INTRAVENOUS THERAPY	0.502518	990	497	64.00
65.00	06500 RESPIRATORY THERAPY	0.186258	43,374	8,079	65.00
66.00	06600 PHYSICAL THERAPY	0.625477	7,719	4,828	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.557899	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.970422	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.189537	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.782860	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.638629	2,306	1,473	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.369996	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.411083	372,412	153,092	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.486348	4,983	2,423	75.00
76.00	03160 STRESS TESTING	0.000000	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.500635	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.173724	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100 EMERGENCY	0.290238	249,361	72,374	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.434017	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,225,096	347,023	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)		1,225,096		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140110

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

Worksheet E  
Part A  
Date/Time Prepared:  
2/27/2014 1:54 pm

		Title XVIII	Hospital	PPS
		0	before 1/1	on/after 1/1
			1.00	1.01
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>				
1.00	DRG Amounts Other than Outlier Payments		7,237,544	1.00
2.00	Outlier payments for discharges. (see instructions)		77,482	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		70.54	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment ( sum of lines 22 and 28)		0	29.00
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.50	30.00
31.00	Percentage of Medicaid patient days (see instructions)		21.37	31.00
32.00	Sum of lines 30 and 31		22.87	32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.08	33.00
34.00	Disproportionate share adjustment (see instructions)		584,794	34.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>				
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: 140110

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

Worksheet E  
Part A  
Date/Time Prepared:  
2/27/2014 1:54 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 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0		46.00
47.00	Subtotal (see instructions)		7,899,820		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		7,795,925		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		7,899,820		49.00
50.00	Payment for inpatient program capital (from worksheet L, Parts I, II, as applicable)		582,649		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from worksheet E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0		56.00
57.00	Routine service other pass through costs (from wkst D, Part III, column 9, lines 30-35).		0		57.00
58.00	Ancillary service other pass through costs worksheet D, Part IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		8,482,469		59.00
60.00	Primary payer payments		11,412		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		8,471,057		61.00
62.00	Deductibles billed to program beneficiaries		998,972		62.00
63.00	Coinsurance billed to program beneficiaries		4,335		63.00
64.00	Allowable bad debts (see instructions)		406,415		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		264,170		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		303,318		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		7,731,920		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)		30,093		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		0		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)	2013	237,815		70.97
70.98	Low Volume Payment-3		0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,999,828		71.00
71.01	Sequestration adjustment (see instructions)		79,998		71.01
72.00	Interim payments		7,730,369		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		189,461		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		360,951		75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>					
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: 140110	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part A Date/Time Prepared: 2/27/2014 1:54 pm	
		Title XVIII	Hospital	PPS	
		0	before 1/1 1.00	on/after 1/1 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:140110

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

Worksheet DSH  
Date/Time Prepared:  
2/27/2014 1:54 pm

		Title XVIII			Hospital	PPS	
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
<b>CALCULATION OF THE DSH PAYMENT PERCENTAGE</b>							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	1.50	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	21.37	0.00			21.37	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	22.87	0.00			21.37	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)	70.54	0.00			70.54	5.00
6.00	Disproportionate Share Payment Percentage (transfer to worksheet E, Part A, line 33)	8.08	0.00			6.85	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	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 geater 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")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
<b>CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS</b>							
15.00	In-State Medicaid paid days (worksheet S-2, line 24, column 1)	1,455	0			1,455	15.00
16.00	In-State Medicaid eligible unpaid paid days (worksheet S-2, line 24, column 2)	185	0			185	16.00
17.00	Out-of-State Medicaid paid days (worksheet S-2, line 24, column 3)	0	0			0	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)	13	0			13	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)	1,653	0			1,653	21.00
22.00	Total patient days (worksheet S-3, Part I, Column 8, Line 14)	7,620	0			7,620	22.00
23.00	Plus total labor room days (worksheet S-3, Part I, Column 8, Line 32)	115	0			115	23.00
24.00	Plus total employee discount days (worksheet S-3, Part I, Column 8, Line 30)	0	0			0	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)	7,735	0			7,735	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	21.37	0.00			21.37	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140110		Period: From 10/01/2012 To 09/30/2013		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 2/27/2014 1:54 pm	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
<b>CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE</b>							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	8.08		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		8.08		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.		8.08		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	
<b>DETERMINATION OF PROVIDER TYPE</b>							
32.00	Does the hospital qualify under the Pickle ammendment? (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-)	True				True	34.00
35.00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	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:140110	Period: From 10/01/2012 To 09/30/2013	Worksheet DSH Date/Time Prepared: 2/27/2014 1:54 pm
		Title XVIII	Hospital	PPS

		Revised Percentage 6.00	
<b>CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE</b>			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	6.85	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00
30.00	Line 28 or 29 as applicable	6.85	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.	6.85	31.00

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01			
	0	1.00	2.00	3.00	4.00			
1.00	DRG amounts other than outlier payments	1.00	7,237,544	0	0	7,237,544	1.00	
2.00	Outlier payments for discharges (see instructions)	2.00	77,482	0	0	77,482	2.00	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00	
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	5.00	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00	
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	Amount from worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00	
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0808	0.0808	0.0808	0.0808	10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	584,794	0	0	584,794	11.00	
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	7,899,820	0	0	7,899,820	13.00	
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	48.00	7,795,925	0	0	7,795,925	14.00	
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	7,899,820	0	0	7,899,820	15.00	
16.00	Payment for inpatient program capital (from worksheet L, Parts I, as applicable)	50.00	582,649	0	0	582,649	16.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00	
19.00	<b>SUBTOTAL</b>			0	0	8,482,469	19.00	
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	575,560	0	0	575,560	20.00	
21.00	Capital DRG outlier payments	2.00	7,089	0	0	7,089	21.00	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	22.00	
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	24.00	
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	0	0	0	0	25.00	
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	582,649	0	0	582,649	26.00	
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00		
27.00	Low volume adjustment factor				0.000000	0.028036	27.00	
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			0		28.00	
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				237,815	29.00	
100.00	Transfer low volume adjustments to W/S E Part A.		Y				100.00	

		Total (Col 2 through 4)	Title XVIII	Hospital	PPS
		5.00			
1.00	DRG amounts other than outlier payments	7,237,544			1.00
2.00	Outlier payments for discharges (see instructions)	77,482			2.00
3.00	Operating outlier reconciliation	0			3.00
4.00	Managed care simulated payments	0			4.00
<b>Indirect Medical Education Adjustment</b>					
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)				5.00
6.00	IME payment adjustment (see instructions)	0			6.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>					
7.00	Amount from Worksheet E Part A, line 27 (see instructions)				7.00
8.00	IME adjustment (see instructions)	0			8.00
9.00	Total IME payment (sum of lines 6 and 8)	0			9.00
<b>Disproportionate Share Adjustment</b>					
10.00	Allowable disproportionate share percentage (see instructions)				10.00
11.00	Disproportionate share adjustment (see instructions)	584,794			11.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>					
12.00	Total ESRD additional payment (see instructions)	0			12.00
13.00	Subtotal (see instructions)	7,899,820			13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	7,795,925			14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	7,899,820			15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	582,649			16.00
17.00	Special add-on payments for new technologies	0			17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	0			18.00
19.00	SUBTOTAL	8,482,469			19.00
		5.00			
20.00	Capital DRG other than outlier	575,560			20.00
21.00	Capital DRG outlier payments	7,089			21.00
22.00	Indirect medical education percentage (see instructions)				22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	0			23.00
24.00	Allowable disproportionate share percentage (see instructions)				24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	0			25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	582,649			26.00
		5.00			
27.00	Low volume adjustment factor				27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	0			28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	237,815			29.00
100.00	Transfer low volume adjustments to W/S E Part A.				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN:140110

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

Worksheet E  
Part B  
Date/Time Prepared:  
2/27/2014 1:54 pm

		Title XVIII		Hospital	PPS
		before 1/1	on/after 1/1	1.00	1.01
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>					
1.00	Medical and other services (see instructions)			6,541	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			2,902,343	2.00
3.00	PPS payments			1,615,769	3.00
4.00	Outlier payment (see instructions)			82,591	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.722	5.00
6.00	Line 2 times line 5			2,095,492	6.00
7.00	Sum of line 3 plus line 4 divided by line 6			81.05	7.00
8.00	Transitional corridor payment (see instructions)			337,562	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			6,541	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable charges</b>					
12.00	Ancillary service charges			17,546	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)			17,546	14.00
<b>Customary charges</b>					
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)			17,546	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			11,005	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)			6,541	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)			7,324,876	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
25.00	Deductibles and coinsurance (for CAH, see instructions)			147	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,572,081	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			5,759,189	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)			0	28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			5,759,189	30.00
31.00	Primary payer payments			536	31.00
32.00	Subtotal (line 30 minus line 31)			5,758,653	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>					
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			303,795	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			197,467	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			234,596	36.00
37.00	Subtotal (see instructions)			5,956,120	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			5,956,120	40.00
40.01	Sequestration adjustment (see instructions)			59,561	40.01
41.00	Interim payments			5,774,466	41.00
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)			122,093	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>					
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
				<b>Overrides</b>	
				1.00	
<b>WORKSHEET OVERRIDE VALUES</b>					
112.00	Override of Ancillary service charges (line 12)				0.112.00



CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN:140110 Component CCN:14s110	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part B Date/Time Prepared: 2/27/2014 1:54 pm	PPS
Title XVIII	Subprovider - IPF		
<b>WORKSHEET OVERRIDE VALUES</b>			Overrides 1.00
112.00 override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN:140110

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 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		7,832,067		5,361,996	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	
<b>Program to Provider</b>							
3.01	ADJUSTMENTS TO PROVIDER	09/30/2013	176,680	09/30/2013	114,472	3.01	
3.02			0	09/30/2013	334,935	3.02	
3.03		10/09/2012	968		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
<b>Provider to Program</b>							
3.50	ADJUSTMENTS TO PROGRAM	04/12/2013	138,753	10/09/2012	7,964	3.50	
3.51		09/30/2013	140,593	09/30/2013	28,973	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)		-101,698		412,470	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)		7,730,369		5,774,466	4.00	
<b>TO BE COMPLETED BY CONTRACTOR</b>							
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	
<b>Program to Provider</b>							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
<b>Provider to Program</b>							
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		189,461		122,093	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		7,919,830		5,896,559	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:140110  
Component CCN:14S110

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm  
PPS

Title XVIII

Subprovider -  
IPF

		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		1,189,324		58	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
	<b>Program to Provider</b>					
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
	<b>Provider to Program</b>					
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)		1,189,324		58	4.00
	<b>TO BE COMPLETED BY CONTRACTOR</b>					
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
	<b>Program to Provider</b>					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	<b>Provider to Program</b>					
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		444		0	6.02
7.00	Total Medicare program liability (see instructions)		1,188,880		58	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN:140110	Period: From 10/01/2012 To 09/30/2013	Worksheet E-1 Part II Date/Time Prepared: 2/27/2014 1:54 pm
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA 54102 from wkst S-3, Part I column 15 line 14		2,328	1.00
2.00	Medicare days from wkst S-3, Part I, column 6 sum of lines 1, 8-12		3,894	2.00
3.00	Medicare HMO days from wkst S-3, Part I, column 6. line 2		335	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12		7,017	4.00
5.00	Total hospital charges from wkst C, Part I, column 8 line 200		184,721,533	5.00
6.00	Total hospital charity care charges from wkst S-10, column 3 line 20		7,492,454	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)		1,404,530	8.00
9.00	Sequestration adjustment amount (see instructions)		28,091	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		1,376,439	10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)		1,456,189	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)		-79,750	32.00
				<b>overrides</b>
				1.00
<b>CONTRACTOR OVERRIDES</b>				
108.00	Override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:140110	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part II Date/Time Prepared: 2/27/2014 1:54 pm
		Component CCN:145110	Title XVIII	Subprovider - IPF
				PPS
				1.00
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		1,384,733	1.00
2.00	Net IPF PPS Outlier Payments		28,727	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)		13.841096	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)		1,413,460	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)		1,413,460	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		1,413,460	18.00
19.00	Deductibles		205,826	19.00
20.00	Subtotal (line 18 minus line 19)		1,207,634	20.00
21.00	Coinsurance		6,745	21.00
22.00	Subtotal (line 20 minus line 21)		1,200,889	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		1,200,889	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)		0	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)		1,200,889	31.00
31.01	Sequestration adjustment (see instructions)		12,009	31.01
32.00	Interim payments		1,189,324	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		-444	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from worksheet E-3, Part II, line 2		28,727	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

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

Provider CCN: 140110

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

Worksheet G

Date/Time Prepared: 2/27/2014 1:54 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	4,151,455	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	29,864,309	0	0	0	4.00
5.00	Other receivable	4,588,567	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-21,949,358	0	0	0	6.00
7.00	Inventory	1,470,677	0	0	0	7.00
8.00	Prepaid expenses	423,063	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	18,548,713	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	3,123,081	0	0	0	12.00
13.00	Land improvements	2,862,859	0	0	0	13.00
14.00	Accumulated depreciation	-2,382,957	0	0	0	14.00
15.00	Buildings	72,060,797	0	0	0	15.00
16.00	Accumulated depreciation	-56,293,492	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	35,022,773	0	0	0	19.00
20.00	Accumulated depreciation	-27,468,146	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	5,043,743	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	31,968,658	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	22,830,234	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	22,830,234	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	73,347,605	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	9,269,134	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,764,311	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5,313,981	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19,347,426	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	19,347,426	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	54,000,179	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)	54,000,179	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	73,347,605	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140110

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

Worksheet G-1

Date/Time Prepared:  
2/27/2014 1:54 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		53,583,458		
2.00	Net income (loss) (from wkst. G-3, line 29)		416,721			2.00
3.00	Total (sum of line 1 and line 2)		54,000,179		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0	0	5.00
6.00		0		0	0	6.00
7.00		0		0	0	7.00
8.00		0		0	0	8.00
9.00		0		0	0	9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		54,000,179		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0	0	13.00
14.00		0		0	0	14.00
15.00		0		0	0	15.00
16.00		0		0	0	16.00
17.00		0		0	0	17.00
18.00	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)		54,000,179		0	19.00

  

	Endowment Fund	Plant Fund			
	6.00	7.00	8.00		
	1.00	Fund balances at beginning of period	0		
2.00	Net income (loss) (from wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			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	Deductions (debit adjustments) (specify)		0		12.00
13.00			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: 140110

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
<b>General Inpatient Routine Services</b>					
1.00	Hospital	9,376,738		9,376,738	1.00
2.00	SUBPROVIDER - IPF	9,315,536		9,315,536	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	18,692,274		18,692,274	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>					
11.00	INTENSIVE CARE UNIT	1,966,748		1,966,748	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)	1,966,748		1,966,748	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	20,659,022		20,659,022	17.00
18.00	Ancillary services	36,392,484	104,082,470	140,474,954	18.00
19.00	Outpatient services	3,845,646	14,813,967	18,659,613	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,857,063	2,857,063	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	1	2,070,880	2,070,881	26.00
27.00	OTHER PATIENT	1,284,477	3,264,710	4,549,187	27.00
27.01	STAT CHARGES	224,204	229,602	453,806	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	62,405,834	127,318,692	189,724,526	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per wkst. A, column 3, line 200)		68,734,480		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		68,734,480		43.00

## STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140110

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

Worksheet G-3

Date/Time Prepared:  
2/27/2014 1:54 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	189,724,526	1.00
2.00	Less contractual allowances and discounts on patients' accounts	126,181,496	2.00
3.00	Net patient revenues (line 1 minus line 2)	63,543,030	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	68,734,480	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,191,450	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	785,446	6.00
7.00	Income from investments	1,486,682	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	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	450,673	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	10,432	17.00
18.00	Revenue from sale of medical records and abstracts	3,596	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	425	21.00
22.00	Rental of hospital space	791,068	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER RENTAL INCOME	23,010	24.00
24.01	OTHER INCOME	1,980,821	24.01
24.02	GAIN ON SALE OF ASSETS	76,018	24.02
25.00	Total other income (sum of lines 6-24)	5,608,171	25.00
26.00	Total (line 5 plus line 25)	416,721	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	416,721	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140110

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

Worksheet H

HHA CCN: 147048

Date/Time Prepared:  
2/27/2014 1:54 pm

		Home Health Agency I		PPS				
		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	
<b>GENERAL SERVICE COST CENTERS</b>								
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	314,895	0	1,315	1,189	180,722	498,121	5.00
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	676,566	0	48,637	0	0	725,203	6.00
7.00	Physical Therapy	367,576	0	13,789	12,558	0	393,923	7.00
8.00	Occupational Therapy	17,165	0	2,339	0	0	19,504	8.00
9.00	Speech Pathology	13,556	0	1,049	0	0	14,605	9.00
10.00	Medical Social Services	5,088	0	720	0	0	5,808	10.00
11.00	Home Health Aide	28,647	0	7,129	0	0	35,776	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
<b>HHA NONREIMBURSABLE SERVICES</b>								
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	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,423,493	0	74,978	13,747	180,722	1,692,940	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			
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	5,229	503,350	-1,213	502,137			5.00
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	0	725,203	0	725,203			6.00
7.00	Physical Therapy	0	393,923	0	393,923			7.00
8.00	Occupational Therapy	0	19,504	0	19,504			8.00
9.00	Speech Pathology	0	14,605	0	14,605			9.00
10.00	Medical Social Services	0	5,808	0	5,808			10.00
11.00	Home Health Aide	0	35,776	0	35,776			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	5,229	1,698,169	-1,213	1,696,956			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: 140110

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

Worksheet H-1 Part I Date/Time Prepared: 2/27/2014 1:54 pm

HHA CCN: 147048

Home Health Agency I

PPS

	Net Expenses for cost Allocation (from wkst. H, col. 10)	Capital Related Costs			Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment					
	0	1.00	2.00	3.00	4.00	4A.00		
<b>GENERAL SERVICE COST CENTERS</b>								
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	4.00
5.00	Administrative and General	502,137	0	0	0	0	502,137	5.00
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	725,203	0	0	0	0	725,203	6.00
7.00	Physical Therapy	393,923	0	0	0	0	393,923	7.00
8.00	Occupational Therapy	19,504	0	0	0	0	19,504	8.00
9.00	Speech Pathology	14,605	0	0	0	0	14,605	9.00
10.00	Medical Social Services	5,808	0	0	0	0	5,808	10.00
11.00	Home Health Aide	35,776	0	0	0	0	35,776	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
<b>HHA NONREIMBURSABLE SERVICES</b>								
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	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,696,956	0	0	0	0	1,696,956	24.00
	Administrative & General	5.00	Total (cols. 4A + 5)					
			6.00					
<b>GENERAL SERVICE COST CENTERS</b>								
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	502,137						5.00
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	304,775	1,029,978					6.00
7.00	Physical Therapy	165,551	559,474					7.00
8.00	Occupational Therapy	8,197	27,701					8.00
9.00	Speech Pathology	6,138	20,743					9.00
10.00	Medical Social Services	2,441	8,249					10.00
11.00	Home Health Aide	15,035	50,811					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
<b>HHA NONREIMBURSABLE SERVICES</b>								
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	0	0					22.00
23.00	All Others (specify)	0	0					23.00
24.00	Total (sum of lines 1-23)		1,696,956					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 140110  
HHA CCN: 147048

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

Worksheet H-1  
Part II  
Date/Time Prepared:  
2/27/2014 1:54 pm

Home Health  
Agency I

PPS

	Capital Related Costs						Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation			
	1.00	2.00	3.00	4.00	5A.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>								
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			4.00
5.00	Administrative and General	0	0	0		-502,137	1,194,819	5.00
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	0	0	0	0	0	725,203	6.00
7.00	Physical Therapy	0	0	0	0	0	393,923	7.00
8.00	Occupational Therapy	0	0	0	0	0	19,504	8.00
9.00	Speech Pathology	0	0	0	0	0	14,605	9.00
10.00	Medical Social Services	0	0	0	0	0	5,808	10.00
11.00	Home Health Aide	0	0	0	0	0	35,776	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
<b>HHA NONREIMBURSABLE SERVICES</b>								
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	0	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	-502,137	1,194,819	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		502,137	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.420262	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140110  
HHA CCN: 147048

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

Worksheet H-2  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

Home Health  
Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP					
		1.00	2.00	4.00				
	0	1.00	2.00	4.00	4A	5.00		
1.00 Administrative and General	0	0	68,455	106,774	175,229	55,157	1.00	
2.00 Skilled Nursing Care	1,029,978	0	0	229,408	1,259,386	396,420	2.00	
3.00 Physical Therapy	559,474	0	0	124,637	684,111	215,339	3.00	
4.00 Occupational Therapy	27,701	0	0	5,820	33,521	10,551	4.00	
5.00 Speech Pathology	20,743	0	0	4,597	25,340	7,976	5.00	
6.00 Medical Social Services	8,249	0	0	1,725	9,974	3,140	6.00	
7.00 Home Health Aide	50,811	0	0	9,714	60,525	19,052	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)	1,696,956	0	68,455	482,675	2,248,086	707,635	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	

  

Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
	7.00	8.00	9.00	10.00	11.00	13.00	
		7.00	8.00	9.00	10.00	11.00	13.00
1.00 Administrative and General	0	0	44,244	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	44,244	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140110

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

Worksheet H-2  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

HHA CCN: 147048

Home Health  
Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	PARAMED ED PRGM	
		14.00	15.00	16.00	17.00	19.00	23.00	
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
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	274,630	0	274,630				1.00
2.00	Skilled Nursing Care	1,655,806	0	1,655,806	166,855	1,822,661		2.00
3.00	Physical Therapy	899,450	0	899,450	90,637	990,087		3.00
4.00	Occupational Therapy	44,072	0	44,072	4,441	48,513		4.00
5.00	Speech Pathology	33,316	0	33,316	3,357	36,673		5.00
6.00	Medical Social Services	13,114	0	13,114	1,321	14,435		6.00
7.00	Home Health Aide	79,577	0	79,577	8,019	87,596		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
20.00	Total (sum of lines 1-19) (2)	2,999,965	0	2,999,965	274,630	2,999,965		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.				0.100769			21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140110  
HHA CCN: 147048

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

Worksheet H-2  
Part II  
Date/Time Prepared: 2/27/2014 1:54 pm  
PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation 5A	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	0	68,087	314,895	0	175,229	0	1.00
2.00 Skilled Nursing Care	0	0	676,566	0	1,259,386	0	2.00
3.00 Physical Therapy	0	0	367,576	0	684,111	0	3.00
4.00 Occupational Therapy	0	0	17,165	0	33,521	0	4.00
5.00 Speech Pathology	0	0	13,556	0	25,340	0	5.00
6.00 Medical Social Services	0	0	5,088	0	9,974	0	6.00
7.00 Home Health Aide	0	0	28,647	0	60,525	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	68,087	1,423,493		2,248,086	0	20.00
21.00 Total cost to be allocated	0	68,455	482,675		707,635	0	21.00
22.00 Unit cost multiplier	0.000000	1.005405	0.339078		0.314772	0.000000	22.00
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	NURSING ADMINISTRATION (HOURS SUPERVISED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
	8.00	9.00	10.00	11.00	13.00	14.00	
1.00 Administrative and General	0	1,456	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)	0	1,456	0	0	0	0	20.00
21.00 Total cost to be allocated	0	44,244	0	0	0	0	21.00
22.00 Unit cost multiplier	0.000000	30.387363	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140110  
HHA CCN: 147048

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

Worksheet H-2  
Part II  
Date/Time Prepared:  
2/27/2014 1:54 pm  
PPS

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140110

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

Worksheet H-3  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm  
PPS

HHA CCN: 147048

Title XVIII

Home Health Agency I

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	1,822,661		1,822,661	7,270	250.71	1.00
2.00	Physical Therapy	3.00	990,087	0	990,087	4,488	220.61	2.00
3.00	Occupational Therapy	4.00	48,513	0	48,513	316	153.52	3.00
4.00	Speech Pathology	5.00	36,673	0	36,673	130	282.10	4.00
5.00	Medical Social Services	6.00	14,435		14,435	93	155.22	5.00
6.00	Home Health Aide	7.00	87,596		87,596	780	112.30	6.00
7.00	Total (sum of lines 1-6)		2,999,965	0	2,999,965	13,077		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits		Ratio (col. 3 ÷ col. 4)
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

**Limitation Cost Computation**

8.00	Skilled Nursing Care		99914	2,547	1,625		8.00
9.00	Physical Therapy		99914	1,615	1,379		9.00
10.00	Occupational Therapy		99914	103	53		10.00
11.00	Speech Pathology		99914	43	16		11.00
12.00	Medical Social Services		99914	34	45		12.00
13.00	Home Health Aide		99914	294	296		13.00
14.00	Total (sum of lines 8-13)			4,636	3,414		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	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

Cost Center Description	Part A	Program Visits		Part A	Cost of Services		
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Part A	Not Subject to Deductibles & Coinsurance	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	2,547	1,625		638,558	407,404	1.00
2.00	Physical Therapy	1,615	1,379		356,285	304,221	2.00
3.00	Occupational Therapy	103	53		15,813	8,137	3.00
4.00	Speech Pathology	43	16		12,130	4,514	4.00
5.00	Medical Social Services	34	45		5,277	6,985	5.00
6.00	Home Health Aide	294	296		33,016	33,241	6.00
7.00	Total (sum of lines 1-6)	4,636	3,414		1,061,079	764,502	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140110  
HHA CCN: 147048

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

Worksheet H-3  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm  
PPS

Title XVIII

Home Health  
Agency I

Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00	
<b>Limitation Cost Computation</b>								
8.00	Skilled Nursing Care						8.00	
9.00	Physical Therapy						9.00	
10.00	Occupational Therapy						10.00	
11.00	Speech Pathology						11.00	
12.00	Medical Social Services						12.00	
13.00	Home Health Aide						13.00	
14.00	Total (sum of lines 8-13)						14.00	
		<b>Program Covered Charges</b>			<b>Cost of Services</b>			
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	
<b>Supplies and Drugs Cost Computations</b>								
15.00	Cost of Medical Supplies						15.00	
16.00	Cost of Drugs		0	0		0	0 16.00	
Cost Center Description		Total Program Cost (sum of cols. 9-10)						
		12.00						
<b>PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION</b>								
<b>Cost Per Visit Computation</b>								
1.00	Skilled Nursing Care	1,045,962						1.00
2.00	Physical Therapy	660,506						2.00
3.00	Occupational Therapy	23,950						3.00
4.00	Speech Pathology	16,644						4.00
5.00	Medical Social Services	12,262						5.00
6.00	Home Health Aide	66,257						6.00
7.00	Total (sum of lines 1-6)	1,825,581						7.00
Cost Center Description								
		12.00						
<b>Limitation Cost Computation</b>								
8.00	Skilled Nursing Care						8.00	
9.00	Physical Therapy						9.00	
10.00	Occupational Therapy						10.00	
11.00	Speech Pathology						11.00	
12.00	Medical Social Services						12.00	
13.00	Home Health Aide						13.00	
14.00	Total (sum of lines 8-13)						14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140110    Period: From 10/01/2012 To 09/30/2013    Worksheet H-3 Part II Date/Time Prepared: 2/27/2014 1:54 pm  
 HHA CCN: 147048    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	
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>						
1.00 Physical Therapy	66.00	0.625477	0	0	0col. 2, line 2.00	1.00
2.00 Occupational Therapy	67.00	0.557899	0	0	0col. 2, line 3.00	2.00
3.00 Speech Pathology	68.00	0.970422	0	0	0col. 2, line 4.00	3.00
4.00 Cost of Medical Supplies	71.00	0.638629	0	0	0col. 2, line 15.00	4.00
5.00 Cost of Drugs	73.00	0.411083	0	0	0col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 140110	Period: From 10/01/2012	Worksheet H-4 Part I-II Date/Time Prepared: 2/27/2014 1:54 pm
	HHA CCN: 147048	To 09/30/2013	
	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		
<b>PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES</b>					
<b>Reasonable Cost of Part A &amp; Part B Services</b>					
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
<b>Customary Charges</b>					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00
			<b>Part A Services</b>	<b>Part B Services</b>	
			1.00	2.00	
<b>PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT</b>					
10.00	Total reasonable cost (see instructions)		0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		723,646	567,187	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		4,016	3,910	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		18,455	11,495	13.00
14.00	Total PPS Reimbursement - PEP Episodes		21,805	11,906	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		560	1,764	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0	16.00
17.00	Total Other Payments		0	0	17.00
18.00	DME Payments		0	0	18.00
19.00	Oxygen Payments		0	0	19.00
20.00	Prosthetic and Orthotic Payments		0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		768,482	596,262	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		768,482	596,262	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)		768,482	596,262	26.00
27.00	Reimbursable bad debts (from your records)		0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		768,482	596,262	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)		768,482	596,262	31.00
31.01	Sequestration adjustment (see instructions)		6,746	5,812	31.01
32.00	Interim payments (see instructions)		761,736	590,450	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: 140110  
HHA CCN: 147048

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

Worksheet H-5  
Date/Time Prepared:  
2/27/2014 1:54 pm  
PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		761,736		590,450	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
<b>Program to Provider</b>						
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
<b>Provider to Program</b>						
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)		761,736		590,450	4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>						
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
<b>Program to Provider</b>						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
<b>Provider to Program</b>						
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		6,746		5,812	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		768,482		596,262	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: 140110  
Hospice CCN: 141570

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

Worksheet K  
Date/Time Prepared:  
2/27/2014 1:54 pm

		Salaries (from wkst. K-1)	Employee Benefits (from wkst. K-2)	Transportatio n (see inst.)	Hospice I Contracted Services (from wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	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	45,862	0	0	0	24,196	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	0	0	0	17,840	0	9.00
10.00	Nursing Care	98,191	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	612	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	32,231	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	17,098	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	54,497	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
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	7,600	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	22,822	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
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
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	49,769	38.00
39.00	Total (sum of lines 1 thru 38)	193,994	0	0	25,440	151,284	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140110  
Hospice CCN: 141570

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

Worksheet K  
Date/Time Prepared:  
2/27/2014 1:54 pm

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Hospice I Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	70,058	355	70,413	-1,008	69,405	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	17,840	0	17,840	-17,840	0	9.00
10.00	Nursing Care	98,191	0	98,191	0	98,191	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	612	0	612	0	612	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	32,231	0	32,231	0	32,231	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	17,098	0	17,098	0	17,098	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	54,497	0	54,497	0	54,497	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
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	7,600	0	7,600	0	7,600	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	22,822	0	22,822	0	22,822	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
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
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	49,769	0	49,769	0	49,769	38.00
39.00	Total (sum of lines 1 thru 38)	370,718	355	371,073	-18,848	352,225	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140110  
Hospice CCN: 141570

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

Worksheet K-1  
Date/Time Prepared:  
2/27/2014 1:54 pm

		Administrator	Director	Social Services	Hospice I Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	98,191	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	32,231	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
<b>OTHER HOSPICE SERVICE COSTS</b>							
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
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
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	32,231	0	98,191	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140110

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

Worksheet K-1

Hospice CCN: 141570

Date/Time Prepared:  
2/27/2014 1:54 pm

		Total Therapists	Aides	All-Other	Hospice I Total (1)	
		6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>						
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	45,862	45,862	6.00
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
<b>VISITING SERVICES</b>						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	98,191	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	612	0	0	612	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	32,231	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		17,098	0	17,098	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>						
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
<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
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)	612	17,098	45,862	193,994	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES  
 Provider CCN: 140110  
 Hospice CCN: 141570  
 Period: From 10/01/2012 To 09/30/2013  
 Worksheet K-3  
 Date/Time Prepared: 2/27/2014 1:54 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
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
<b>OTHER HOSPICE SERVICE COSTS</b>							
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
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES

Provider CCN: 140110

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

Worksheet K-3

Hospice CCN: 141570

Date/Time Prepared:  
2/27/2014 1:54 pm

		Total Therapists	Aides	All-other	Hospice I Total (1)	
		6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>						
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
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
<b>VISITING SERVICES</b>						
9.00	Physician Services		0	17,840	17,840	9.00
10.00	Nursing Care		0	0	0	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	0	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>						
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	7,600	7,600	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
<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
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	25,440	25,440	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140110  
Hospice CCN: 141570

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

Worksheet K-4  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

		CAPITAL RELATED COST				
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATIO N
		0	1.00	2.00	3.00	4.00
<b>GENERAL SERVICE COST CENTERS</b>						
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	69,405	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
<b>VISITING SERVICES</b>						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	98,191	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	612	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	32,231	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	17,098	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	54,497	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>						
22.00	Drugs, Biological and Infusion Therapy	0	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	7,600	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	22,822	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
<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
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	49,769	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	352,225	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140110  
Hospice CCN: 141570

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

Worksheet K-4  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	Hospice I TOTAL (col. 5A ± col. 6)	
		5.00	5A	6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>						
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	69,405	69,405		6.00
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
<b>VISITING SERVICES</b>						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	0	98,191	24,096	122,287	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	612	150	762	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	32,231	7,910	40,141	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	17,098	4,196	21,294	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	54,497	13,374	67,871	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>						
22.00	Drugs, Biological and Infusion Therapy	0	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	7,600	1,865	9,465	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	22,822	5,601	28,423	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
<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
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	49,769	12,213	61,982	38.00
39.00	Total (sum of lines 1 thru 38)	0	352,225		352,225	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140110  
Hospice CCN: 141570

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

Worksheet K-4  
Part II  
Date/Time Prepared:  
2/27/2014 1:54 pm

		CAPITAL RELATED COST		PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATIO N (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT (\$ VALUE)				
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
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
<b>OTHER HOSPICE SERVICE COSTS</b>							
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
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0	0	0	0	39.00
40.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	40.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140110

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

Worksheet K-4  
Part II  
Date/Time Prepared:  
2/27/2014 1:54 pm

Hospice CCN: 141570

Hospice I

		RECONCILIATIO N	ADMINISTRATIV E & GENERAL (ACC. COST)	
		6A	6.00	
<b>GENERAL SERVICE COST CENTERS</b>				
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	-69,405	282,820	6.00
<b>INPATIENT CARE SERVICE</b>				
7.00	Inpatient - General Care	0	0	7.00
8.00	Inpatient - Respite Care	0	0	8.00
<b>VISITING SERVICES</b>				
9.00	Physician Services	0	0	9.00
10.00	Nursing Care	0	98,191	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	612	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	32,231	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	17,098	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	54,497	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>				
22.00	Drugs, Biological and Infusion Therapy	0	0	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	7,600	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	22,822	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
<b>HOSPICE NONREIMBURSABLE SERVICE</b>				
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	49,769	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		69,405	39.00
40.00	Unit Cost Multiplier		0.245403	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140110  
Hospice CCN: 141570

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

Worksheet K-5  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MBLE EQUIP			
		1.00	2.00			
	0			4.00	4A	
1.00 Administrative and General			1,005	15,551	16,556	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	122,287	0	0	33,293	155,580	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	762	0	0	208	970	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	40,141	0	0	10,929	51,070	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	21,294	0	0	5,798	27,092	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	67,871	0	0	0	67,871	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	9,465	0	0	0	9,465	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	28,423	0	0	0	28,423	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	61,982	0	0	0	61,982	33.00
34.00 Total (sum of lines 1 thru 33) (2)	352,225	0	1,005	65,779	419,009	34.00
35.00 Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140110  
Hospice CCN: 141570

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

Worksheet K-5  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description	Hospice I					DIETARY		
	ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	10.00			
1.00 Administrative and General	5,211	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	0	0	0	0	0	0	0	4.00
5.00 Nursing Care	48,973	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	305	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	16,075	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	8,528	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	21,364	0	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	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	2,979	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	8,947	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	19,510	0	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	131,892	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: 140110  
Hospice CCN: 141570

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

Worksheet K-5  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description	Hospice I					MEDICAL RECORDS & LIBRARY		
	CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY				
	11.00	13.00	14.00	15.00	16.00			
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	0	0	0	0	0	0	0	4.00
5.00 Nursing Care	0	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	0	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	0	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	0	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	0	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)	0	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: 140110  
Hospice CCN: 141570

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

Worksheet K-5  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description		Hospice I				Intern & Residents Cost & Post Stepdown Adjustments	
		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	PARAMED ED PRGM	Subtotal (cols. 4A-23)		
		17.00	19.00	23.00	24.00	25.00	
1.00	Administrative and General	0	0	0	21,767	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	204,553	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	1,275	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	67,145	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	35,620	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	89,235	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	12,444	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	37,370	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	81,492	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	550,901	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140110

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

Worksheet K-5  
Part I  
Date/Time Prepared:  
2/27/2014 1:54 pm

Hospice CCN: 141570

Hospice I

Cost Center Description		Subtotal	Allocated	Total Hospice	
		(cols. 24 ± 25)	Hospice A&G (See Part II)	Costs (cols. 26 ± 27)	
		26.00	27.00	28.00	
1.00	Administrative and General				1.00
2.00	Inpatient - General Care	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	3.00
4.00	Physician Services	0	0	0	4.00
5.00	Nursing Care	204,553	8,416	212,969	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	6.00
7.00	Physical Therapy	1,275	52	1,327	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	67,145	2,762	69,907	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	35,620	1,465	37,085	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	15.00
16.00	Other	89,235	3,671	92,906	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	12,444	512	12,956	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	37,370	1,537	38,907	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	81,492	3,352	84,844	33.00
34.00	Total (sum of lines 1 thru 33) (2)	550,901		550,901	34.00
35.00	Unit Cost Multiplier (see instructions)		0.041137		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 140110  
Hospice CCN: 141570

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

Worksheet K-5  
Part II  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
					5A	5.00	
1.00 Administrative and General	0	1,000	45,862	0	0	16,556	1.00
2.00 Inpatient - General Care	0	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	98,191	0	0	155,580	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	612	0	0	970	7.00
8.00 Occupational Therapy	0	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	32,231	0	0	51,070	10.00
11.00 Spiritual Counseling	0	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	17,098	0	0	27,092	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	67,871	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	9,465	22.00
23.00 Imaging Services	0	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	28,423	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	61,982	33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	1,000	193,994			419,009	34.00
35.00 Total cost to be allocated	0	1,005	65,779			131,892	35.00
36.00 Unit Cost Multiplier (see instructions)	0.000000	1.005000	0.339077			0.314771	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 140110  
Hospice CCN: 141570

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

Worksheet K-5  
Part II  
Date/Time Prepared:  
2/27/2014 1:54 pm

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 140110  
Hospice CCN: 141570

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

Worksheet K-5  
Part II  
Date/Time Prepared:  
2/27/2014 1:54 pm

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 140110  
Hospice CCN: 141570

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

Worksheet K-5  
Part II  
Date/Time Prepared:  
2/27/2014 1:54 pm

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

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 140110  
Hospice CCN: 141570

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

Worksheet K-5  
Part III  
Date/Time Prepared:  
2/27/2014 1:54 pm

Cost Center Description	Wkst. C, Part I, col. 11 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
<b>ANCILLARY SERVICE COST CENTERS</b>				
1.00 PHYSICAL THERAPY	66.00	0.625477	0	0 1.00
2.00 OCCUPATIONAL THERAPY	67.00	0.557899	0	0 2.00
3.00 SPEECH PATHOLOGY	68.00	0.970422	0	0 3.00
4.00 DRUGS CHARGED TO PATIENTS	73.00	0.411083	0	0 4.00
5.00 DURABLE MEDICAL EQUIP-RENTED	96.00			5.00
6.00 LABORATORY	60.00	0.189154	0	0 6.00
6.01 BLOOD LABORATORY	60.01			6.01
7.00 MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.638629	0	0 7.00
8.00 OTHER OUTPATIENT SERVICE COST CENTER	93.00			8.00
9.00 RADIOLOGY-THERAPEUTIC	55.00			9.00
10.00 STRESS TESTING	76.00	0.000000	0	0 10.00
10.01 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01	1.511934	0	0 10.01
10.97 CARDIAC REHABILITATION	76.97	0.173724	0	0 10.97
11.00 Totals (sum of lines 1-10)				0 11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 140110  
Hospice CCN: 141570

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

Worksheet K-6  
Date/Time Prepared:  
2/27/2014 1:54 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				466,057	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				4,454	2.00
3.00	Average cost per diem (line 1 divided by line 2)				104.64	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	3,523				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	368,647				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		291			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		30,450			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	372				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	38,926				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		91			10.00
11.00	Aggregate NF cost (line 3 times line 10)		9,522			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			640		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			66,970		13.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 140110

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

Worksheet L  
Parts I-III  
Date/Time Prepared:  
2/27/2014 1:54 pm

Title XVIII

Hospital

PPS

		1.00	
<b>PART I - FULLY PROSPECTIVE METHOD</b>			
<b>CAPITAL FEDERAL AMOUNT</b>			
1.00	Capital DRG other than outlier	575,560	1.00
2.00	Capital DRG outlier payments	7,089	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	19.22	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (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)	582,649	12.00
		1.00	
<b>PART II - PAYMENT UNDER REASONABLE COST</b>			
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	
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>			
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