

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet S Parts I-III Date/Time Prepared: 2/25/2013 10:06 am
--	----------------------	---	---

PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 2/25/2013	Time: 10:06 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CAMERON MEMORIAL COMMUNITY (151315) for the cost reporting period beginning 10/01/2011 and ending 09/30/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information
 ECR: Date: 2/25/2013 Time: 10:06 am
 MqgBiosEp1bt7IvQwE4LD.YpyBoSO
 1YrER0FGIXIyvqbsH0DF2a4RjIw0n:
 khDt0ILNES0nvKaF
 PI: Date: 2/25/2013 Time: 10:06 am
 pJ6PGQFYVIlcT4Mdeop6GbV.GCWm1
 iVKT70.eWOONkVX:.zmWUm0tz9YEdO
 N.iK4ket5l0sCi17

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

 Title

 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	498,073	31,611	113,729	0 1.00
2.00	Subprovider - IPF	0	0	0	0	0 2.00
3.00	Subprovider - IRF	0	0	0	0	0 3.00
4.00	SUBPROVIDER I	0	0	0	0	0 4.00
5.00	Swing bed - SNF	0	135,224	0	0	0 5.00
6.00	Swing bed - NF	0	0	0	0	0 6.00
7.00	SKILLED NURSING FACILITY	0	0	0	0	0 7.00
8.00	NURSING FACILITY	0	0	0	0	0 8.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	0 9.00
10.00	RURAL HEALTH CLINIC I	0	0	0	0	0 10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0 11.00
12.00	CMHC I	0	0	0	0	0 12.00
200.00	Total	0	633,297	31,611	113,729	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: 151315		Period: From 10/01/2011 To 09/30/2012		Worksheet S-2 Part I Date/Time Prepared: 2/25/2013 10:02 am							
1.00		2.00		3.00		4.00							
Hospital and Hospital Health Care Complex Address:													
1.00	Street: 416 E MAUMEE STREET			PO Box:						1.00			
2.00	City: ANGOLA			State: IN		Zip Code: 47803-		County: STEUBEN		2.00			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:													
3.00	Hospital		CAMERON MEMORIAL COMMUNITY	151315	99915	1	02/01/2003	N	O	P	3.00		
4.00	Subprovider - IPF										4.00		
5.00	Subprovider - IRF										5.00		
6.00	Subprovider - (Other)										6.00		
7.00	Swing Beds - SNF		CAMERON MEMORIAL COMMUNITY	15Z315	99915		02/01/2003	N	O	N	7.00		
8.00	Swing Beds - NF										8.00		
9.00	Hospital-Based SNF										9.00		
10.00	Hospital-Based NF										10.00		
11.00	Hospital-Based OLTC										11.00		
12.00	Hospital-Based HHA		CAMERON HOME HEALTH CARE	157117	99915		04/01/1984	N	P	N	12.00		
13.00	Separately Certified ASC										13.00		
14.00	Hospital-Based Hospice		CAMERON HOSPICE	151561	99915		05/01/1997				14.00		
15.00	Hospital-Based Health Clinic - RHC										15.00		
16.00	Hospital-Based Health Clinic - FQHC										16.00		
17.00	Hospital-Based (CMHC) I										17.00		
18.00	Renal Dialysis										18.00		
19.00	Other										19.00		
							From:	To:					
							1.00	2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2011	09/30/2012		20.00			
21.00	Type of Control (see instructions)						2		21.00				
Inpatient PPS Information													
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						2		N		23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days						
		1.00	2.00	3.00	4.00	5.00	6.00						
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.						0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.						0	0	0	0	0	0	25.00
							Urban/Rural S	Date of Geogr					
							1.00	2.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						2				26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2				27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0				35.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/25/2013 10:02 am		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N				
		1.00				
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.					39.00
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00		61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151315

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

Worksheet S-2
Part I
Date/Time Prepared:
2/25/2013 10:02 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/25/2013 10:02 am		
		1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00	
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00	
		V		XIX		
		1.00		2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	Y	109.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/25/2013 10:02 am	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	157,077	7,461		0
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		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	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.			N	145.00
				1.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151315		Period: From 10/01/2011 To 09/30/2012		Worksheet S-2 Part I Date/Time Prepared: 2/25/2013 10:02 am		
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						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)						676,997	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part II Date/Time Prepared: 2/25/2013 10:02 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A			
		Description	Y/N	Date	
		0	1.00	2.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/29/2012		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)	N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part II Date/Time Prepared: 2/25/2013 10:02 am
---	--	----------------------	---	---

		Part A		
Description		Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		1.00	2.00	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	Y		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	Y		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	Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y		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.	Y		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RENEE	ESSLINGER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-383-4253	RESSLINGER@BKD.COM	43.00

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/29/2012	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)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGING CONSULTANT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151315

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

Worksheet S-3
Part I
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
	Line Number		Avai lable		
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	23	8,418	64,344.00	1.00
2.00 HMO					2.00
3.00 HMO IPF Subprovider					3.00
4.00 HMO IRF Subprovider					4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					5.00
6.00 Hospital Adults & Peds. Swing Bed NF					6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		23	8,418	64,344.00	7.00
8.00 INTENSIVE CARE UNIT	31.00	2	732	1,176.00	8.00
9.00 CORONARY CARE UNIT					9.00
10.00 BURN INTENSIVE CARE UNIT					10.00
11.00 SURGICAL INTENSIVE CARE UNIT					11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY	43.00				13.00
14.00 Total (see instructions)		25	9,150	65,520.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY	101.00				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE	116.00	0	0		24.00
25.00 CMHC - CMHC					25.00
26.00 RURAL HEALTH CLINIC	88.00				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				26.25
27.00 Total (sum of lines 14-26)		25			27.00
28.00 Observation Bed Days					28.00
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151315

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

Worksheet S-3
Part I
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,105	310	2,681		1.00
2.00 HMO		469	0			2.00
3.00 HMO IPF Subprovider		0	0			3.00
4.00 HMO IRF Subprovider		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	371	0	371		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	234		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,476	310	3,286		7.00
8.00 INTENSIVE CARE UNIT	0	24	3	49		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	0		210	321		13.00
14.00 Total (see instructions)	0	1,500	523	3,656		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	1,797	1,113	4,741		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE		0	0	0		24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		24	272		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)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151315

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

Worksheet S-3
Part I
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	320	1.00
2.00 HMO					0	2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	282.10	0.00	0	320	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	13.17	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00	2.06	0.00			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	297.33	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151315

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

Worksheet S-3
Part I
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	138	880		1.00
2.00 HMO				2.00
3.00 HMO IPF Subprovider				3.00
4.00 HMO IRF Subprovider				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF				5.00
6.00 Hospital Adults & Peds. Swing Bed NF				6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00 INTENSIVE CARE UNIT				8.00
9.00 CORONARY CARE UNIT				9.00
10.00 BURN INTENSIVE CARE UNIT				10.00
11.00 SURGICAL INTENSIVE CARE UNIT				11.00
12.00 OTHER SPECIAL CARE (SPECIFY)				12.00
13.00 NURSERY				13.00
14.00 Total (see instructions)	138	880		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 151315 Component CCN: 157117		Period: From 10/01/2011 To 09/30/2012		Worksheet S-4 Date/Time Prepared: 2/25/2013 10:02 am			
				Home Health Agency I		PPS			
							1.00		
0.00	County	STUEBEN					0.00		
		Title V	Title XVIII	Title XIX	Other	Total			
		1.00	2.00	3.00	4.00	5.00			
HOME HEALTH AGENCY STATISTICAL DATA									
1.00	Home Health Aide Hours	0	480	537	1,271	2,288		1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	115.00	0.00	0.00	0.00		2.00	
		Number of Employees (Full Time Equivalent)							
		Enter the number of hours in your normal work week			Staff	Contract	Total		
		0			1.00	2.00	3.00		
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES									
3.00	Administrator and Assistant Administrator(s)	0.00			0.00	0.00	0.00		3.00
4.00	Director(s) and Assistant Director(s)				1.39	0.00	1.39		4.00
5.00	Other Administrative Personnel				3.03	0.00	3.03		5.00
6.00	Direct Nursing Service				3.92	0.00	3.92		6.00
7.00	Nursing Supervisor				0.00	0.00	0.00		7.00
8.00	Physical Therapy Service				1.04	0.00	1.04		8.00
9.00	Physical Therapy Supervisor				0.00	0.00	0.00		9.00
10.00	Occupational Therapy Service				0.35	0.00	0.35		10.00
11.00	Occupational Therapy Supervisor				0.00	0.00	0.00		11.00
12.00	Speech Pathology Service				0.07	0.00	0.07		12.00
13.00	Speech Pathology Supervisor				0.00	0.00	0.00		13.00
14.00	Medical Social Service				0.33	0.00	0.33		14.00
15.00	Medical Social Service Supervisor				0.00	0.00	0.00		15.00
16.00	Home Health Aide				1.10	0.00	1.10		16.00
17.00	Home Health Aide Supervisor				0.00	0.00	0.00		17.00
18.00	Other (specify)				1.94	0.00	1.94		18.00
HOME HEALTH AGENCY CBSA CODES									
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				1			19.00	
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).				99915			20.00	
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)			
		Without Outliers	With Outliers	3.00	4.00	5.00			
		1.00	2.00	3.00	4.00	5.00			
PPS ACTIVITY DATA									
21.00	Skilled Nursing Visits	635	49	32	3	719		21.00	
22.00	Skilled Nursing Visit Charges	119,556	9,526	6,202	583	135,867		22.00	
23.00	Physical Therapy Visits	668	0	6	4	678		23.00	
24.00	Physical Therapy Visit Charges	136,919	0	1,232	821	138,972		24.00	
25.00	Occupational Therapy Visits	113	0	1	0	114		25.00	
26.00	Occupational Therapy Visit Charges	22,345	0	199	0	22,544		26.00	
27.00	Speech Pathology Visits	24	0	0	0	24		27.00	
28.00	Speech Pathology Visit Charges	4,766	0	0	0	4,766		28.00	
29.00	Medical Social Service Visits	14	0	0	0	14		29.00	
30.00	Medical Social Service Visit Charges	3,453	0	0	0	3,453		30.00	
31.00	Home Health Aide Visits	246	0	1	1	248		31.00	
32.00	Home Health Aide Visit Charges	13,343	0	53	53	13,449		32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,700	49	40	8	1,797		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)	300,382	9,526	7,686	1,457	319,051		35.00	
36.00	Total Number of Episodes (standard/non outlier)	100		13	1	114		36.00	
37.00	Total Number of Outlier Episodes		1		0	1		37.00	
38.00	Total Non-Routine Medical Supply Charges	19,414	286	748	0	20,448		38.00	

HOSPITAL IDENTIFICATION DATA

Provider CCN: 151315
Component CCN: 151561

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

Worksheet S-9
Parts I & II
Date/Time Prepared:
2/25/2013 10:02 am

		Unduplicated Days				All Other	
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility		
		1.00	2.00	3.00	4.00		
PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	1.00
2.00	Routine Home Care	3,681	0	0	0	0	2.00
3.00	Inpatient Respite Care	24	0	0	0	0	3.00
4.00	General Inpatient Care	10	0	0	0	0	4.00
5.00	Total Hospice Days	3,715	0	0	0	0	5.00
Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	77	0	0	0	0	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00			7.00
8.00	Average Length of Stay (line 5/line 6)	48.25	0.00	0.00	0.00	0.00	8.00
9.00	Unduplicated Census Count	0	0	0	0	0	9.00

HOSPITAL IDENTIFICATION DATA		Provider CCN: 151315 Component CCN: 151561	Period: From 10/01/2011 To 09/30/2012	Worksheet S-9 Parts I & II Date/Time Prepared: 2/25/2013 10:02 am
		Hospice I		

		Unduplicated Days	
		Total (sum of cols. 1, 2 & 5)	
		6.00	
PART I - ENROLLMENT DAYS			
1.00	Continuous Home Care	0	1.00
2.00	Routine Home Care	3,681	2.00
3.00	Inpatient Respite Care	24	3.00
4.00	General Inpatient Care	10	4.00
5.00	Total Hospice Days	3,715	5.00
Part II - CENSUS DATA			
6.00	Number of Patients Receiving Hospice Care	77	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare		7.00
8.00	Average Length of Stay (line 5/line 6)	48.25	8.00
9.00	Unduplicated Census Count	0	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet S-10	
				Date/Time Prepared: 2/25/2013 10:02 am	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.451795	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		2,268,184	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		8,513,540	6.00	
7.00	Medicaid cost (line 1 times line 6)		3,846,375	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)		1,578,191	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		111	9.00	
10.00	Stand-alone SCHIP charges		603	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		272	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		161	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,578,352	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	938,644	109,505	1,048,149	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	424,075	49,474	473,549	21.00
22.00	Partial payment by patients approved for charity care	211,920	35,433	247,353	22.00
23.00	Cost of charity care (line 21 minus line 22)	212,155	14,041	226,196	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		4,357,268	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		336,782	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		4,020,486	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		1,816,435	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,042,631	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,620,983	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151315

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

Worksheet A
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT		2,776,400	2,776,400	-1,081,353	1,695,047	1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		865,424	865,424	1,580,974	2,446,398	2.00
4.00 00400 EMPLOYEE BENEFITS	0	6,155,390	6,155,390	0	6,155,390	4.00
5.00 00500 ADMINI STRATIVE & GENERAL	2,616,552	8,423,239	11,039,791	155,808	11,195,599	5.00
7.00 00700 OPERATION OF PLANT	476,201	1,245,535	1,721,736	29,314	1,751,050	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	124,948	124,948	0	124,948	8.00
9.00 00900 HOUSEKEEPING	413,673	138,201	551,874	0	551,874	9.00
10.00 01000 DIETARY	358,478	309,404	667,882	-584,382	83,500	10.00
11.00 01100 CAFETERIA	0	0	0	515,972	515,972	11.00
13.00 01300 NURSING ADMINISTRATION	563,461	12,146	575,607	0	575,607	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	111,720	41,302	153,022	0	153,022	14.00
15.00 01500 PHARMACY	382,471	1,280,526	1,662,997	0	1,662,997	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	435,397	256,899	692,296	0	692,296	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	1,285,909	422,119	1,708,028	143,770	1,851,798	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	25,095	25,095	31.00
43.00 04300 NURSERY	0	0	0	29,499	29,499	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1,363,043	1,596,965	2,960,008	-555,285	2,404,723	50.00
51.00 05100 RECOVERY ROOM	0	0	0	555,285	555,285	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	490,423	70,426	560,849	-198,364	362,485	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,263,951	1,021,435	2,285,386	0	2,285,386	54.00
60.00 06000 LABORATORY	854,515	1,112,505	1,967,020	0	1,967,020	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	34,791	672,976	707,767	-163,045	544,722	65.00
65.01 06501 SLEEP LAB	0	0	0	159,909	159,909	65.01
66.00 06600 PHYSICAL THERAPY	535,873	25,976	561,849	0	561,849	66.00
69.00 06900 ELECTROCARDIOLOGY	0	245,001	245,001	3,136	248,137	69.00
69.01 06901 CARDIAC REHAB	46,544	7,566	54,110	0	54,110	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,223,944	1,223,944	-434,526	789,418	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	434,526	434,526	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03020 CHEMICAL DEPENDENCY	131,126	10,943	142,069	0	142,069	76.00
76.01 03021 ONCOLOGY	0	1,455,407	1,455,407	0	1,455,407	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	91,234	21,669	112,903	0	112,903	90.00
91.00 09100 EMERGENCY	1,345,181	193,352	1,538,533	0	1,538,533	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	644,796	65,267	710,063	18,497	728,560	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE		399,374	399,374	-399,374	0	113.00
114.00 11400 UTILIZATION REVIEW - SNF	0	0	0	0	0	114.00
116.00 11600 HOSPICE	117,584	53,125	170,709	-18,497	152,212	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	13,562,923	30,227,464	43,790,387	216,959	44,007,346	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00 07950 DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01 07951 MOB	0	33,362	33,362	-29,314	4,048	194.01
194.02 07952 COMMUNITY HEALTH	74,698	11,421	86,119	0	86,119	194.02
194.03 07953 ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04 07954 EDUCATION	88,458	29,287	117,745	-117,745	0	194.04
194.05 07955 MARKETING	124,020	309,047	433,067	-138,310	294,757	194.05
194.06 07956 GUEST MEALS	0	0	0	68,410	68,410	194.06
194.07 07957 OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08 07958 CANCER CENTER	0	0	0	0	0	194.08
194.09 07959 URGENT CARE	388,148	648,742	1,036,890	0	1,036,890	194.09
200.00 TOTAL (SUM OF LINES 118-199)	14,238,247	31,259,323	45,497,570	0	45,497,570	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151315

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

Worksheet A
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-575,250	1,119,797	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-415,711	2,030,687	2.00
4.00	00400	EMPLOYEE BENEFITS	-236,483	5,918,907	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,733,169	6,462,430	5.00
7.00	00700	OPERATION OF PLANT	-18,394	1,732,656	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	124,948	8.00
9.00	00900	HOUSEKEEPING	0	551,874	9.00
10.00	01000	DIETARY	-42,674	40,826	10.00
11.00	01100	CAFETERIA	-137,624	378,348	11.00
13.00	01300	NURSING ADMINISTRATION	0	575,607	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	153,022	14.00
15.00	01500	PHARMACY	-168,261	1,494,736	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-868	691,428	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-269,510	1,582,288	30.00
31.00	03100	INTENSIVE CARE UNIT	0	25,095	31.00
43.00	04300	NURSERY	0	29,499	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,080,556	1,324,167	50.00
51.00	05100	RECOVERY ROOM	0	555,285	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	362,485	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,285,386	54.00
60.00	06000	LABORATORY	-8,439	1,958,581	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	544,722	65.00
65.01	06501	SLEEP LAB	0	159,909	65.01
66.00	06600	PHYSICAL THERAPY	0	561,849	66.00
69.00	06900	ELECTROCARDIOLOGY	0	248,137	69.00
69.01	06901	CARDIAC REHAB	0	54,110	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	789,418	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	434,526	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	142,069	76.00
76.01	03021	ONCOLOGY	0	1,455,407	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	112,903	90.00
91.00	09100	EMERGENCY	-9,613	1,528,920	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	728,560	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW - SNF	0	0	114.00
116.00	11600	HOSPICE	0	152,212	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,696,552	36,310,794	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	DAYCARE- INFANT/TODDLER	0	0	194.00
194.01	07951	MOB	0	4,048	194.01
194.02	07952	COMMUNITY HEALTH	0	86,119	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	194.03
194.04	07954	EDUCATION	0	0	194.04
194.05	07955	MARKETING	0	294,757	194.05
194.06	07956	GUEST MEALS	0	68,410	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	194.07
194.08	07958	CANCER CENTER	0	0	194.08
194.09	07959	URGENT CARE	0	1,036,890	194.09
200.00		TOTAL (SUM OF LINES 118-199)	-7,696,552	37,801,018	200.00

RECLASSIFICATIONS

Provider CCN: 151315

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

Worksheet A-6

Date/Time Prepared:
2/25/2013 10:02 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - LABOR & DELIVERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	168,865	0	1.00	
2.00	NURSERY	43.00	29,499	0	2.00	
	TOTALS		198,364	0		
B - PROPERTY INSURANCE RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	74,576	1.00	
	TOTALS		0	74,576		
C - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	276,942	239,030	1.00	
2.00	GUEST MEALS	194.06	36,718	31,692	2.00	
	TOTALS		313,660	270,722		
D - INTEREST EXPENSE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	230,750	1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	168,624	2.00	
	TOTALS		0	399,374		
F - DEPRECIATION EXPENSE RECLASS						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,412,350	1.00	
	TOTALS		0	1,412,350		
G - ICU RECLASS						
1.00	INTENSIVE CARE UNIT	31.00	18,893	6,202	1.00	
	TOTALS		18,893	6,202		
H - ADVERTISING COST RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	16,023	131,706	1.00	
	TOTALS		16,023	131,706		
I - PROPERTY TAX RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	25,671	1.00	
	TOTALS		0	25,671		
L - EDUCATION COST RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	88,458	29,287	1.00	
	TOTALS		88,458	29,287		
M - SLEEP LAB RECLASS						
1.00	SLEEP LAB	65.01	0	159,909	1.00	
2.00	ELECTROCARDIOLOGY	69.00	0	3,136	2.00	
	TOTALS		0	163,045		
O - UTILITIES RECLASS						
1.00	OPERATION OF PLANT	7.00	0	29,314	1.00	
	TOTALS		0	29,314		
P - PUBLIC RELATIONS RECLASS						
1.00	MARKETING	194.05	0	9,419	1.00	
	TOTALS		0	9,419		
R - MSW SALARY RECLASS						
1.00	HOME HEALTH AGENCY	101.00	18,497	0	1.00	
	TOTALS		18,497	0		
S - RECOVERY ROOM SALARY RECLASS						
1.00	RECOVERY ROOM	51.00	555,285	0	1.00	
	TOTALS		555,285	0		
T - IMPANTABLE DEVICE RECLASS						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	434,526	1.00	
	TOTALS		0	434,526		
500.00	Grand Total: Increases		1,209,180	2,986,192	500.00	

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - LABOR & DELIVERY RECLASS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	198,364	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		198,364	0			
B - PROPERTY INSURANCE RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	74,576	12		1.00
	TOTALS		0	74,576			
C - CAFETERIA RECLASS							
1.00	DIETARY	10.00	313,660	270,722	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		313,660	270,722			
D - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	399,374	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	399,374			
F - DEPRECIATION EXPENSE RECLASS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,412,350	9		1.00
	TOTALS		0	1,412,350			
G - ICU RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	18,893	6,202	0		1.00
	TOTALS		18,893	6,202			
H - ADVERTISING COST RECLASS							
1.00	MARKETING	194.05	16,023	131,706	0		1.00
	TOTALS		16,023	131,706			
I - PROPERTY TAX RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	25,671	13		1.00
	TOTALS		0	25,671			
L - EDUCATION COST RECLASS							
1.00	EDUCATION	194.04	88,458	29,287	0		1.00
	TOTALS		88,458	29,287			
M - SLEEP LAB RECLASS							
1.00	RESPIRATORY THERAPY	65.00	0	163,045	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	163,045			
O - UTILITIES RECLASS							
1.00	MOB	194.01	0	29,314	0		1.00
	TOTALS		0	29,314			
P - PUBLIC RELATIONS RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,419	0		1.00
	TOTALS		0	9,419			
R - MSW SALARY RECLASS							
1.00	HOSPICE	116.00	18,497	0	0		1.00
	TOTALS		18,497	0			
S - RECOVERY ROOM SALARY RECLASS							
1.00	OPERATING ROOM	50.00	555,285	0	0		1.00
	TOTALS		555,285	0			
T - IMPANTABLE DEVICE RECLASS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	434,526	0		1.00
	TOTALS		0	434,526			
500.00	Grand Total: Decreases		1,209,180	2,986,192			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151315

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/25/2013 10:02 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,043,373	0	0	0	293,183	1.00
2.00	Land Improvements	23,021,472	603,255	0	603,255	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	15,718,262	546,995	0	546,995	786,064	6.00
7.00	HIT designated Assets	0	786,064	0	786,064	0	7.00
8.00	Subtotal (sum of lines 1-7)	39,783,107	1,936,314	0	1,936,314	1,079,247	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	39,783,107	1,936,314	0	1,936,314	1,079,247	10.00
SUMMARY OF CAPITAL							
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
	9.00	10.00	11.00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,776,400	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	865,424	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,641,824	0	0	0	0	3.00
COMPUTATION OF RATIOS							
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	24,374,914	0	24,374,914	0.724338	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	16,265,257	6,988,852	9,276,405	0.275662	0	2.00
3.00	Total (sum of lines 1-2)	40,640,171	6,988,852	33,651,319	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151315

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/25/2013 10:02 am

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	750,190	0		1.00	
2.00	Land Improvements	23,624,727	0		2.00	
3.00	Buildings and Fixtures	0	0		3.00	
4.00	Building Improvements	0	0		4.00	
5.00	Fixed Equipment	0	0		5.00	
6.00	Movable Equipment	15,479,193	0		6.00	
7.00	HIT designated Assets	786,064	0		7.00	
8.00	Subtotal (sum of lines 1-7)	40,640,174	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	40,640,174	0		10.00	
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,776,400		1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	865,424		2.00	
3.00	Total (sum of lines 1-2)	0	3,641,824		3.00	
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,019,550	0
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,000,570	0
3.00	Total (sum of lines 1-2)	0	0	0	3,020,120	0

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151315

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	74,576	25,671	0	1,119,797	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	30,117	0	0	0	2,030,687	2.00
3.00	Total (sum of lines 1-2)	30,117	74,576	25,671	0	3,150,484	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151315

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

Worksheet A-8

Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center		Line #
			1.00	2.00	3.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-230,750	NEW CAP REL COSTS-BLDG & FIXT		1.00 1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	-138,507	NEW CAP REL COSTS-MVBLE EQUIP		2.00 2.00
3.00 Investment income - other (chapter 2)		0			0.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)	B	-9,507	NEW CAP REL COSTS-MVBLE EQUIP		2.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00 7.00
8.00 Television and radio service (chapter 21)		0			0.00 8.00
9.00 Parking lot (chapter 21)		0			0.00 9.00
10.00 Provider-based physician adjustment	A-8-2	-277,949			10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-288,255			12.00
13.00 Laundry and linen service		0			0.00 13.00
14.00 Cafeteria-employees and guests	B	-137,624	CAFETERIA		11.00 14.00
15.00 Rental of quarters to employee and others		0			0.00 15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00 16.00
17.00 Sale of drugs to other than patients	B	-168,261	PHARMACY		15.00 17.00
18.00 Sale of medical records and abstracts	B	-868	MEDICAL RECORDS & LIBRARY		16.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00 19.00
20.00 Vending machines	B	-29,991	DIETARY		10.00 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY		65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY		66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)			UTILIZATION REVIEW - SNF		114.00 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT		1.00 26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP		2.00 27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***		19.00 28.00
29.00 Physicians' assistant			0		0.00 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***		67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***		68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-262,021	NEW CAP REL COSTS-MVBLE EQUIP		2.00 32.00
33.00 MRI DEPRECIATION CARRYFORWARD ADJUST	A	-5,676	NEW CAP REL COSTS-MVBLE EQUIP		2.00 33.00
33.01 BAD DEBT EXPENSE ADJUSTMENT	A	-4,357,268	ADMINISTRATIVE & GENERAL		5.00 33.01
33.02 LOBBYING EXPENSES	A	-4,172	ADMINISTRATIVE & GENERAL		5.00 33.02
33.03 EMPLOYEE CHRISTMAS PARTY	A	-13,709	ADMINISTRATIVE & GENERAL		5.00 33.03
33.04 PHYSICIAN RECRUITMENT	B	-1,479	ADMINISTRATIVE & GENERAL		5.00 33.04
33.05 MEALS ON WHEELS	B	-12,423	DIETARY		10.00 33.05
33.06 BREAKFAST CART	B	-260	DIETARY		10.00 33.06
33.07 REIMBURSEMENT FOUNDATION DEVELOPMENT	B	-68,542	ADMINISTRATIVE & GENERAL		5.00 33.07
33.08 ANESTHESIA SUBSIDY	A	-1,080,556	OPERATING ROOM		50.00 33.08
33.09 RENTAL INCOME OFFSET - CANCER CENTER	B	-28,143	NEW CAP REL COSTS-BLDG & FIXT		1.00 33.09
33.10 SLEEP CENTER TRAINING INCOME	B	-500	ADMINISTRATIVE & GENERAL		5.00 33.10
33.11 ATM SURCHARGE REVENUE	B	-1,644	ADMINISTRATIVE & GENERAL		5.00 33.11
33.12 DEMOLITION OF 2012 ASSETS	A	-316,357	NEW CAP REL COSTS-BLDG & FIXT		1.00 33.12
33.13 PHYSICIAN GUARANTEE	B	-6,635	EMERGENCY		91.00 33.13
33.14 OP EDUCATION	B	-403	EMPLOYEE BENEFITS		4.00 33.14
33.15 DUMPSTER LEASE	B	-15,094	OPERATION OF PLANT		7.00 33.15
33.16 EMS	B	-2,978	EMERGENCY		91.00 33.16

Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet A-8 Date/Time Prepared: 2/25/2013 10:02 am
----------------------	---	--

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #
			Cost Center	Line #	
	1.00	2.00	3.00	4.00	
33.17 PHYSICIAN GUARANTEE	B	-236,980	ADMINISTRATIVE & GENERAL	5.00	33.17
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,696,552			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151315

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

Worksheet A-8

Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	11	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	9	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	9	32.00
33.00	MRI DEPRECIATION CARRYFORWARD ADJUST	9	33.00
33.01	BAD DEBT EXPENSE ADJUSTMENT	0	33.01
33.02	LOBBYING EXPENSES	0	33.02
33.03	EMPLOYEE CHRISTMAS PARTY	0	33.03
33.04	PHYSICIAN RECRUITMENT	0	33.04
33.05	MEALS ON WHEELS	0	33.05
33.06	BREAKFAST CART	0	33.06
33.07	REIMBURSEMENT FOUNDATION DEVELOPMENT	0	33.07
33.08	ANESTHESIA SUBSIDY	0	33.08
33.09	RENTAL INCOME OFFSET - CANCER CENTER	9	33.09
33.10	SLEEP CENTER TRAINING INCOME	0	33.10
33.11	ATM SURCHARGE REVENUE	0	33.11
33.12	DEMOLITION OF 2012 ASSETS	9	33.12
33.13	PHYSICIAN GUARANTEE	0	33.13
33.14	OP EDUCATION	0	33.14
33.15	DUMPSTER LEASE	0	33.15
33.16	EMS	0	33.16
33.17	PHYSICIAN GUARANTEE	0	33.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 151315

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

Worksheet A-8-1

Date/Time Prepared:
2/25/2013 10:02 am

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		4.00	EMPLOYEE BENEFITS	CMO OVERHEAD - BENEFITS	1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	CMO OVERHEAD - A&G	2.00
3.00		7.00	OPERATION OF PLANT	CMO OVERHEAD - PLANT OPS	3.00
4.00		2.00	NEW CAP REL COSTS-MVBLE EQUIP	RENT PAID TO CMO	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00

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

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

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

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

6.00		C	CAMERON MEDICAL	100.00	6.00
7.00				0.00	7.00
8.00				0.00	8.00
9.00				0.00	9.00
10.00				0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 151315

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

Worksheet A-8-1

Date/Time Prepared:
2/25/2013 10:02 am

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0	236,080	-236,080	0	1.00
2.00	0	48,875	-48,875	0	2.00
3.00	0	3,300	-3,300	0	3.00
4.00	339,494	339,494	0	9	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00
	339,494	627,749	-288,255		

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

Related Organization(s) and/or Home Office			
Name	Percentage of Ownership	Type of Business	
4.00	5.00	6.00	

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151315

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

Worksheet A-8-2

Date/Time Prepared:
2/25/2013 10:02 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	60.00	LABORATORY	18,000	8,439	1.00
2.00	30.00	ADULTS & PEDIATRICS	269,510	269,510	2.00
3.00	0.00		0	0	3.00
4.00	0.00		0	0	4.00
5.00	0.00		0	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			287,510	277,949	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151315

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

Worksheet A-8-2

Date/Time Prepared:
2/25/2013 10:02 am

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	9,561	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	9,561			0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151315

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

Worksheet A-8-2

Date/Time Prepared:
2/25/2013 10:02 am

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151315

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

Worksheet A-8-2

Date/Time Prepared:
2/25/2013 10:02 am

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	8,439	1.00
2.00	0	269,510	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	277,949	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151315		Period: From 10/01/2011 To 09/30/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/25/2013 10:02 am	
				Respiratory Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					3.25	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	2,077.00	16,055.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	60.25	59.07	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	29.54	29.54	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					125,139	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					948,369	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					1,073,508	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					1,073,508	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					1,073,508	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					10,782	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					10,782	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,186	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					11,968	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					11,968	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					1,186	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151315		Period: From 10/01/2011 To 09/30/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/25/2013 10:02 am	
				Respiratory Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	132.00	0.00	0.00	0.00	132.00	47.00
48.00	Overtime rate (see instructions)	88.61	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	11,696.52	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	100.00	0.00	0.00	0.00	100.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	2,080.00	0.00	0.00	0.00	2,080.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	59.07	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	122,866	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	11,697	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	7,797	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	3,900	0	0	0	3,900	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					1,073,508	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					11,968	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					3,900	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					1,089,376	63.00
64.00	Total cost of outside supplier services (from your records)					0	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					10,782	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,186	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					11,968	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,186	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					1,186	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151315

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

Worksheet B
Part I
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	1,119,797	1,119,797				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	2,030,687		2,030,687			2.00
4.00 00400 EMPLOYEE BENEFITS	5,918,907	0	0	5,918,907		4.00
5.00 00500 ADMINISTRATIVE & GENERAL	6,462,430	163,839	297,112	1,131,143	8,054,524	5.00
7.00 00700 OPERATION OF PLANT	1,732,656	152,902	277,279	197,959	2,360,796	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	124,948	13,382	24,268	0	162,598	8.00
9.00 00900 HOUSEKEEPING	551,874	920	1,669	171,966	726,429	9.00
10.00 01000 DIETARY	40,826	40,234	72,962	18,631	172,653	10.00
11.00 01100 CAFETERIA	378,348	19,173	34,768	115,126	547,415	11.00
13.00 01300 NURSING ADMINISTRATION	575,607	4,314	7,823	234,234	821,978	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	153,022	19,853	36,003	46,443	255,321	14.00
15.00 01500 PHARMACY	1,494,736	10,008	18,149	158,995	1,681,888	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	691,428	14,360	26,042	180,997	912,827	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	1,582,288	83,372	151,191	596,903	2,413,754	30.00
31.00 03100 INTENSIVE CARE UNIT	25,095	4,822	8,744	7,854	46,515	31.00
43.00 04300 NURSERY	29,499	3,835	6,954	12,263	52,551	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1,324,167	88,204	159,952	335,789	1,908,112	50.00
51.00 05100 RECOVERY ROOM	555,285	19,959	36,194	230,835	842,273	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	362,485	23,295	42,244	121,410	549,434	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,285,386	57,997	105,175	525,431	2,973,989	54.00
60.00 06000 LABORATORY	1,958,581	32,613	59,141	355,226	2,405,561	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	544,722	8,110	14,707	14,463	582,002	65.00
65.01 06501 SLEEP LAB	159,909	15,952	28,927	0	204,788	65.01
66.00 06600 PHYSICAL THERAPY	561,849	39,764	72,110	222,765	896,488	66.00
69.00 06900 ELECTROCARDIOLOGY	248,137	1,438	2,608	0	252,183	69.00
69.01 06901 CARDIAC REHAB	54,110	16,939	30,718	19,349	121,116	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	789,418	0	0	0	789,418	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	434,526	0	0	0	434,526	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03020 CHEMICAL DEPENDENCY	142,069	23,774	43,113	54,510	263,466	76.00
76.01 03021 ONCOLOGY	1,455,407	106,408	192,965	0	1,754,780	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	112,903	1,869	3,390	37,926	156,088	90.00
91.00 09100 EMERGENCY	1,528,920	54,220	98,325	559,198	2,240,663	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	728,560	13,296	24,112	275,734	1,041,702	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 11400 UTILIZATION REVIEW - SNF	0	0	0	0	0	114.00
116.00 11600 HOSPICE	152,212	2,723	4,937	41,191	201,063	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	36,310,794	1,037,575	1,881,582	5,666,341	35,826,901	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,473	4,485	0	6,958	190.00
194.00 07950 DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01 07951 MOB	4,048	10,296	18,671	0	33,015	194.01
194.02 07952 COMMUNITY HEALTH	86,119	0	0	31,052	117,171	194.02
194.03 07953 ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04 07954 EDUCATION	0	0	0	0	0	194.04
194.05 07955 MARKETING	294,757	8,024	14,551	44,895	362,227	194.05
194.06 07956 GUEST MEALS	68,410	0	0	15,264	83,674	194.06
194.07 07957 OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08 07958 CANCER CENTER	0	0	0	0	0	194.08
194.09 07959 URGENT CARE	1,036,890	61,429	111,398	161,355	1,371,072	194.09
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	37,801,018	1,119,797	2,030,687	5,918,907	37,801,018	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151315

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

Worksheet B
Part I
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,054,524				5.00
7.00	00700	OPERATION OF PLANT	639,237	3,000,033			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	44,027	49,994	256,619		8.00
9.00	00900	HOUSEKEEPING	196,697	3,438	63,422	989,986	9.00
10.00	01000	DIETARY	46,750	150,304	6,751	0	376,458
11.00	01100	CAFETERIA	148,225	71,625	0	42,307	0
13.00	01300	NURSING ADMINISTRATION	222,569	16,116	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	69,134	74,167	0	10,879	0
15.00	01500	PHARMACY	455,408	37,388	0	12,088	0
16.00	01600	MEDICAL RECORDS & LIBRARY	247,168	53,647	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	653,577	311,460	55,050	207,907	370,916
31.00	03100	INTENSIVE CARE UNIT	12,595	18,014	2,033	4,835	5,542
43.00	04300	NURSERY	14,229	14,325	9,534	60,439	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	516,663	329,509	32,014	73,735	0
51.00	05100	RECOVERY ROOM	228,064	74,561	13,309	29,011	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	148,771	87,024	7,235	16,923	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	805,278	216,664	20,592	66,483	0
60.00	06000	LABORATORY	651,359	121,833	194	53,186	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	157,590	30,297	218	8,461	0
65.01	06501	SLEEP LAB	55,451	59,592	3,315	15,714	0
66.00	06600	PHYSICAL THERAPY	242,744	148,549	1,500	44,725	0
69.00	06900	ELECTROCARDIOLOGY	68,284	5,372	218	0	0
69.01	06901	CARDIAC REHAB	32,795	63,280	1,500	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	213,752	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	117,657	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	CHEMICAL DEPENDENCY	71,339	88,815	0	12,088	0
76.01	03021	ONCOLOGY	475,145	397,517	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	42,264	6,983	339	3,626	0
91.00	09100	EMERGENCY	606,709	202,554	37,846	160,767	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	282,064	49,672	0	18,132	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW - SNF					114.00
116.00	11600	HOSPICE	54,442	10,171	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,519,987	2,692,871	255,070	841,306	376,458
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,884	9,240	0	0	0
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0
194.01	07951	MOB	8,940	38,462	1,549	97,911	0
194.02	07952	COMMUNITY HEALTH	31,727	0	0	0	0
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0
194.04	07954	EDUCATION	0	0	0	0	0
194.05	07955	MARKETING	98,081	29,975	0	0	0
194.06	07956	GUEST MEALS	22,657	0	0	0	0
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0
194.08	07958	CANCER CENTER	0	0	0	0	0
194.09	07959	URGENT CARE	371,248	229,485	0	50,769	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	8,054,524	3,000,033	256,619	989,986	376,458

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151315

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

Worksheet B
Part I
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	809,572					11.00
13.00	01300	28,725	1,089,388				13.00
14.00	01400	14,280	0	423,781			14.00
15.00	01500	20,783	0	898	2,208,453		15.00
16.00	01600	38,190	0	167	0	1,251,999	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	120,827	220,573	12,652	0	9,844	30.00
31.00	03100	1,646	2,983	0	0	508	31.00
43.00	04300	1,975	3,586	0	0	4,232	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	57,450	104,861	58,457	0	32,215	50.00
51.00	05100	38,273	69,834	16,563	0	0	51.00
52.00	05200	19,466	35,525	5,189	0	0	52.00
54.00	05400	89,303	162,994	6,078	0	362,547	54.00
60.00	06000	80,455	146,865	93,080	0	376,193	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	1,482	0	3,867	0	38,062	65.00
65.01	06501	0	0	0	0	0	65.01
66.00	06600	39,178	71,535	1,588	0	83,573	66.00
69.00	06900	0	0	567	0	57,738	69.00
69.01	06901	3,539	0	57	0	34,208	69.01
71.00	07100	0	0	135,670	0	0	71.00
72.00	07200	0	0	74,679	0	0	72.00
73.00	07300	0	0	0	2,208,453	0	73.00
76.00	03020	12,181	0	107	0	23,165	76.00
76.01	03021	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	8,107	14,807	2,730	0	39,729	90.00
91.00	09100	106,176	193,792	3,388	0	189,985	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	54,199	62,033	1,203	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
116.00	11600	8,478	0	294	0	0	116.00
118.00		744,713	1,089,388	417,234	2,208,453	1,251,999	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	696	0	0	194.01
194.02	07952	6,050	0	1,360	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	670	0	0	194.04
194.05	07955	10,371	0	405	0	0	194.05
194.06	07956	5,556	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	42,882	0	3,416	0	0	194.09
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		809,572	1,089,388	423,781	2,208,453	1,251,999	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151315

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

Worksheet B
Part I
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
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
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	4,376,560	0	4,376,560	30.00
31.00	03100	94,671	0	94,671	31.00
43.00	04300	160,871	0	160,871	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	3,113,016	0	3,113,016	50.00
51.00	05100	1,311,888	0	1,311,888	51.00
52.00	05200	869,567	0	869,567	52.00
54.00	05400	4,703,928	0	4,703,928	54.00
60.00	06000	3,928,726	0	3,928,726	60.00
64.00	06400	0	0	0	64.00
65.00	06500	821,979	0	821,979	65.00
65.01	06501	338,860	0	338,860	65.01
66.00	06600	1,529,880	0	1,529,880	66.00
69.00	06900	384,362	0	384,362	69.00
69.01	06901	256,495	0	256,495	69.01
71.00	07100	1,138,840	0	1,138,840	71.00
72.00	07200	626,862	0	626,862	72.00
73.00	07300	2,208,453	0	2,208,453	73.00
76.00	03020	471,161	0	471,161	76.00
76.01	03021	2,627,442	0	2,627,442	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
90.00	09000	274,673	0	274,673	90.00
91.00	09100	3,741,880	0	3,741,880	91.00
92.00	09200	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	1,509,005	0	1,509,005	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
114.00	11400				114.00
116.00	11600	274,448	0	274,448	116.00
118.00		34,763,567	0	34,763,567	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	18,082	0	18,082	190.00
194.00	07950	0	0	0	194.00
194.01	07951	180,573	0	180,573	194.01
194.02	07952	156,308	0	156,308	194.02
194.03	07953	0	0	0	194.03
194.04	07954	670	0	670	194.04
194.05	07955	501,059	0	501,059	194.05
194.06	07956	111,887	0	111,887	194.06
194.07	07957	0	0	0	194.07
194.08	07958	0	0	0	194.08
194.09	07959	2,068,872	0	2,068,872	194.09
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		37,801,018	0	37,801,018	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151315

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

Worksheet B
Part II
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	163,839	297,112	460,951	5.00
7.00 00700	OPERATION OF PLANT	0	152,902	277,279	430,181	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	13,382	24,268	37,650	8.00
9.00 00900	HOUSEKEEPING	0	920	1,669	2,589	9.00
10.00 01000	DIETARY	0	40,234	72,962	113,196	10.00
11.00 01100	CAFETERIA	0	19,173	34,768	53,941	11.00
13.00 01300	NURSING ADMINISTRATION	0	4,314	7,823	12,137	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	19,853	36,003	55,856	14.00
15.00 01500	PHARMACY	0	10,008	18,149	28,157	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	14,360	26,042	40,402	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	83,372	151,191	234,563	30.00
31.00 03100	INTENSIVE CARE UNIT	0	4,822	8,744	13,566	31.00
43.00 04300	NURSERY	0	3,835	6,954	10,789	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	88,204	159,952	248,156	50.00
51.00 05100	RECOVERY ROOM	0	19,959	36,194	56,153	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	23,295	42,244	65,539	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	57,997	105,175	163,172	54.00
60.00 06000	LABORATORY	0	32,613	59,141	91,754	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	8,110	14,707	22,817	65.00
65.01 06501	SLEEP LAB	0	15,952	28,927	44,879	65.01
66.00 06600	PHYSICAL THERAPY	0	39,764	72,110	111,874	66.00
69.00 06900	ELECTROCARDIOLOGY	0	1,438	2,608	4,046	69.00
69.01 06901	CARDIAC REHAB	0	16,939	30,718	47,657	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03020	CHEMICAL DEPENDENCY	0	23,774	43,113	66,887	76.00
76.01 03021	ONCOLOGY	0	106,408	192,965	299,373	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	1,869	3,390	5,259	90.00
91.00 09100	EMERGENCY	0	54,220	98,325	152,545	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	13,296	24,112	37,408	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW - SNF					114.00
116.00 11600	HOSPICE	0	2,723	4,937	7,660	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,037,575	1,881,582	2,919,157	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,473	4,485	6,958	190.00
194.00 07950	DAYCARE-INFANT/TODDLER	0	0	0	0	194.00
194.01 07951	MOB	0	10,296	18,671	28,967	194.01
194.02 07952	COMMUNITY HEALTH	0	0	0	0	194.02
194.03 07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	194.03
194.04 07954	EDUCATION	0	0	0	0	194.04
194.05 07955	MARKETING	0	8,024	14,551	22,575	194.05
194.06 07956	GUEST MEALS	0	0	0	0	194.06
194.07 07957	OUTSIDE LAUNDRY	0	0	0	0	194.07
194.08 07958	CANCER CENTER	0	0	0	0	194.08
194.09 07959	URGENT CARE	0	61,429	111,398	172,827	194.09
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,119,797	2,030,687	3,150,484	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151315

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

Worksheet B
Part II
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	460,951				5.00
7.00	00700	OPERATION OF PLANT	36,583	466,764			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,520	7,778	47,948		8.00
9.00	00900	HOUSEKEEPING	11,257	535	11,851	26,232	9.00
10.00	01000	DIETARY	2,675	23,385	1,261	0	10.00
11.00	01100	CAFETERIA	8,483	11,144	0	1,121	0
13.00	01300	NURSING ADMINISTRATION	12,737	2,507	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	3,956	11,539	0	288	0
15.00	01500	PHARMACY	26,063	5,817	0	320	0
16.00	01600	MEDICAL RECORDS & LIBRARY	14,145	8,347	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	37,404	48,459	10,286	5,512	138,449
31.00	03100	INTENSIVE CARE UNIT	721	2,803	380	128	2,068
43.00	04300	NURSERY	814	2,229	1,781	1,601	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	29,568	51,267	5,982	1,954	0
51.00	05100	RECOVERY ROOM	13,052	11,601	2,487	769	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,514	13,540	1,352	448	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,082	33,710	3,848	1,762	0
60.00	06000	LABORATORY	37,277	18,956	36	1,409	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	9,019	4,714	41	224	0
65.01	06501	SLEEP LAB	3,173	9,272	619	416	0
66.00	06600	PHYSICAL THERAPY	13,892	23,112	280	1,185	0
69.00	06900	ELECTROCARDIOLOGY	3,908	836	41	0	0
69.01	06901	CARDIAC REHAB	1,877	9,846	280	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,233	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,733	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	CHEMICAL DEPENDENCY	4,083	13,818	0	320	0
76.01	03021	ONCOLOGY	27,192	61,846	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	2,419	1,087	63	96	0
91.00	09100	EMERGENCY	34,721	31,515	7,071	4,260	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	16,142	7,728	0	480	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW - SNF					114.00
116.00	11600	HOSPICE	3,116	1,582	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	430,359	418,973	47,659	22,293	140,517
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	108	1,438	0	0	0
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0
194.01	07951	MOB	512	5,984	289	2,594	0
194.02	07952	COMMUNITY HEALTH	1,816	0	0	0	0
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0
194.04	07954	EDUCATION	0	0	0	0	0
194.05	07955	MARKETING	5,613	4,664	0	0	0
194.06	07956	GUEST MEALS	1,297	0	0	0	0
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0
194.08	07958	CANCER CENTER	0	0	0	0	0
194.09	07959	URGENT CARE	21,246	35,705	0	1,345	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	460,951	466,764	47,948	26,232	140,517

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151315

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

Worksheet B
Part II
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	74,689					11.00
13.00	01300	2,650	30,031				13.00
14.00	01400	1,317	0	72,956			14.00
15.00	01500	1,917	0	155	62,429		15.00
16.00	01600	3,523	0	29	0	66,446	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	11,147	6,081	2,178	0	522	30.00
31.00	03100	152	82	0	0	27	31.00
43.00	04300	182	99	0	0	225	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	5,300	2,891	10,064	0	1,710	50.00
51.00	05100	3,531	1,925	2,851	0	0	51.00
52.00	05200	1,796	979	893	0	0	52.00
54.00	05400	8,239	4,493	1,046	0	19,241	54.00
60.00	06000	7,423	4,049	16,024	0	19,967	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	137	0	666	0	2,020	65.00
65.01	06501	0	0	0	0	0	65.01
66.00	06600	3,614	1,972	273	0	4,435	66.00
69.00	06900	0	0	98	0	3,064	69.00
69.01	06901	327	0	10	0	1,815	69.01
71.00	07100	0	0	23,357	0	0	71.00
72.00	07200	0	0	12,856	0	0	72.00
73.00	07300	0	0	0	62,429	0	73.00
76.00	03020	1,124	0	18	0	1,229	76.00
76.01	03021	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	748	408	470	0	2,108	90.00
91.00	09100	9,796	5,342	583	0	10,083	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	5,000	1,710	207	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
116.00	11600	782	0	51	0	0	116.00
118.00		68,705	30,031	71,829	62,429	66,446	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	120	0	0	194.01
194.02	07952	558	0	234	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	115	0	0	194.04
194.05	07955	957	0	70	0	0	194.05
194.06	07956	513	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	3,956	0	588	0	0	194.09
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		74,689	30,031	72,956	62,429	66,446	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/25/2013 10:02 am
-------------------------------------	--	----------------------	---	---

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
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
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	494,601	0	494,601	30.00
31.00	03100	19,927	0	19,927	31.00
43.00	04300	17,720	0	17,720	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	356,892	0	356,892	50.00
51.00	05100	92,369	0	92,369	51.00
52.00	05200	93,061	0	93,061	52.00
54.00	05400	281,593	0	281,593	54.00
60.00	06000	196,895	0	196,895	60.00
64.00	06400	0	0	0	64.00
65.00	06500	39,638	0	39,638	65.00
65.01	06501	58,359	0	58,359	65.01
66.00	06600	160,637	0	160,637	66.00
69.00	06900	11,993	0	11,993	69.00
69.01	06901	61,812	0	61,812	69.01
71.00	07100	35,590	0	35,590	71.00
72.00	07200	19,589	0	19,589	72.00
73.00	07300	62,429	0	62,429	73.00
76.00	03020	87,479	0	87,479	76.00
76.01	03021	388,411	0	388,411	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
90.00	09000	12,658	0	12,658	90.00
91.00	09100	255,916	0	255,916	91.00
92.00	09200	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	68,675	0	68,675	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
114.00	11400				114.00
116.00	11600	13,191	0	13,191	116.00
118.00		2,829,435	0	2,829,435	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	8,504	0	8,504	190.00
194.00	07950	0	0	0	194.00
194.01	07951	38,466	0	38,466	194.01
194.02	07952	2,608	0	2,608	194.02
194.03	07953	0	0	0	194.03
194.04	07954	115	0	115	194.04
194.05	07955	33,879	0	33,879	194.05
194.06	07956	1,810	0	1,810	194.06
194.07	07957	0	0	0	194.07
194.08	07958	0	0	0	194.08
194.09	07959	235,667	0	235,667	194.09
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		3,150,484	0	3,150,484	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151315

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

Worksheet B-1
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	116,812					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		116,812				2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	14,238,247			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	17,091	17,091	2,721,033	-8,054,524	29,746,494	5.00
7.00 00700	OPERATION OF PLANT	15,950	15,950	476,201	0	2,360,796	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,396	1,396	0	0	162,598	8.00
9.00 00900	HOUSEKEEPING	96	96	413,673	0	726,429	9.00
10.00 01000	DIETARY	4,197	4,197	44,818	0	172,653	10.00
11.00 01100	CAFETERIA	2,000	2,000	276,942	0	547,415	11.00
13.00 01300	NURSING ADMINISTRATION	450	450	563,461	0	821,978	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,071	2,071	111,720	0	255,321	14.00
15.00 01500	PHARMACY	1,044	1,044	382,471	0	1,681,888	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,498	1,498	435,397	0	912,827	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	8,697	8,697	1,435,881	0	2,413,754	30.00
31.00 03100	INTENSIVE CARE UNIT	503	503	18,893	0	46,515	31.00
43.00 04300	NURSERY	400	400	29,499	0	52,551	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	9,201	9,201	807,758	0	1,908,112	50.00
51.00 05100	RECOVERY ROOM	2,082	2,082	555,285	0	842,273	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,430	2,430	292,059	0	549,434	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	6,050	6,050	1,263,951	0	2,973,989	54.00
60.00 06000	LABORATORY	3,402	3,402	854,515	0	2,405,561	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	846	846	34,791	0	582,002	65.00
65.01 06501	SLEEP LAB	1,664	1,664	0	0	204,788	65.01
66.00 06600	PHYSICAL THERAPY	4,148	4,148	535,873	0	896,488	66.00
69.00 06900	ELECTROCARDIOLOGY	150	150	0	0	252,183	69.00
69.01 06901	CARDIAC REHAB	1,767	1,767	46,544	0	121,116	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	789,418	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	434,526	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03020	CHEMICAL DEPENDENCY	2,480	2,480	131,126	0	263,466	76.00
76.01 03021	ONCOLOGY	11,100	11,100	0	0	1,754,780	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	195	195	91,234	0	156,088	90.00
91.00 09100	EMERGENCY	5,656	5,656	1,345,181	0	2,240,663	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	1,387	1,387	663,293	0	1,041,702	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
114.00 11400	UTILIZATION REVIEW - SNF						114.00
116.00 11600	HOSPICE	284	284	99,087	0	201,063	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	108,235	108,235	13,630,686	-8,054,524	27,772,377	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	258	258	0	0	6,958	190.00
194.00 07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01 07951	MOB	1,074	1,074	0	0	33,015	194.01
194.02 07952	COMMUNITY HEALTH	0	0	74,698	0	117,171	194.02
194.03 07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04 07954	EDUCATION	0	0	0	0	0	194.04
194.05 07955	MARKETING	837	837	107,997	0	362,227	194.05
194.06 07956	GUEST MEALS	0	0	36,718	0	83,674	194.06
194.07 07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08 07958	CANCER CENTER	0	0	0	0	0	194.08
194.09 07959	URGENT CARE	6,408	6,408	388,148	0	1,371,072	194.09
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)	1,119,797	2,030,687	5,918,907		8,054,524	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	9.586318	17.384233	0.415705		0.270772	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		460,951	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.015496	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151315

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

Worksheet B-1
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	83,771				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,396	10,605			8.00
9.00	00900	HOUSEKEEPING	96	2,621	819		9.00
10.00	01000	DIETARY	4,197	279	0	11,073	10.00
11.00	01100	CAFETERIA	2,000	0	35	0	19,672
13.00	01300	NURSING ADMINISTRATION	450	0	0	0	698
14.00	01400	CENTRAL SERVICES & SUPPLY	2,071	0	9	0	347
15.00	01500	PHARMACY	1,044	0	10	0	505
16.00	01600	MEDICAL RECORDS & LIBRARY	1,498	0	0	0	928
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,697	2,275	172	10,910	2,936
31.00	03100	INTENSIVE CARE UNIT	503	84	4	163	40
43.00	04300	NURSERY	400	394	50	0	48
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,201	1,323	61	0	1,396
51.00	05100	RECOVERY ROOM	2,082	550	24	0	930
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,430	299	14	0	473
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,050	851	55	0	2,170
60.00	06000	LABORATORY	3,402	8	44	0	1,955
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	846	9	7	0	36
65.01	06501	SLEEP LAB	1,664	137	13	0	0
66.00	06600	PHYSICAL THERAPY	4,148	62	37	0	952
69.00	06900	ELECTROCARDIOLOGY	150	9	0	0	0
69.01	06901	CARDIAC REHAB	1,767	62	0	0	86
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	CHEMICAL DEPENDENCY	2,480	0	10	0	296
76.01	03021	ONCOLOGY	11,100	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	195	14	3	0	197
91.00	09100	EMERGENCY	5,656	1,564	133	0	2,580
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,387	0	15	0	1,317
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
114.00	11400	UTILIZATION REVIEW - SNF					
116.00	11600	HOSPICE	284	0	0	0	206
118.00		SUBTOTALS (SUM OF LINES 1-117)	75,194	10,541	696	11,073	18,096
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	258	0	0	0	0
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0
194.01	07951	MOB	1,074	64	81	0	0
194.02	07952	COMMUNITY HEALTH	0	0	0	0	147
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0
194.04	07954	EDUCATION	0	0	0	0	0
194.05	07955	MARKETING	837	0	0	0	252
194.06	07956	GUEST MEALS	0	0	0	0	135
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0
194.08	07958	CANCER CENTER	0	0	0	0	0
194.09	07959	URGENT CARE	6,408	0	42	0	1,042
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	3,000,033	256,619	989,986	376,458	809,572
203.00		Unit cost multiplier (Wkst. B, Part I)	35.812310	24.197926	1,208.774115	33.997833	41.153518
204.00		Cost to be allocated (per Wkst. B, Part II)	466,764	47,948	26,232	140,517	74,689
205.00		Unit cost multiplier (Wkst. B, Part II)	5.571904	4.521264	32.029304	12.690057	3.796716

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151315

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

Worksheet B-1
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	301,652				13.00
14.00	01400	0	2,465,814			14.00
15.00	01500	0	5,226	100		15.00
16.00	01600	0	971	0	96,148	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	61,077	73,616	0	756	30.00
31.00	03100	826	0	0	39	31.00
43.00	04300	993	0	0	325	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	29,036	340,139	0	2,474	50.00
51.00	05100	19,337	96,373	0	0	51.00
52.00	05200	9,837	30,192	0	0	52.00
54.00	05400	45,133	35,365	0	27,842	54.00
60.00	06000	40,667	541,592	0	28,890	60.00
64.00	06400	0	0	0	0	64.00
65.00	06500	0	22,500	0	2,923	65.00
65.01	06501	0	0	0	0	65.01
66.00	06600	19,808	9,241	0	6,418	66.00
69.00	06900	0	3,298	0	4,434	69.00
69.01	06901	0	329	0	2,627	69.01
71.00	07100	0	789,418	0	0	71.00
72.00	07200	0	434,526	0	0	72.00
73.00	07300	0	0	100	0	73.00
76.00	03020	0	625	0	1,779	76.00
76.01	03021	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	0	0	0	0	88.00
89.00	08900	0	0	0	0	89.00
90.00	09000	4,100	15,887	0	3,051	90.00
91.00	09100	53,661	19,712	0	14,590	91.00
92.00	09200					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	17,177	7,000	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
114.00	11400					114.00
116.00	11600	0	1,711	0	0	116.00
118.00		301,652	2,427,721	100	96,148	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	4,048	0	0	194.01
194.02	07952	0	7,916	0	0	194.02
194.03	07953	0	0	0	0	194.03
194.04	07954	0	3,897	0	0	194.04
194.05	07955	0	2,357	0	0	194.05
194.06	07956	0	0	0	0	194.06
194.07	07957	0	0	0	0	194.07
194.08	07958	0	0	0	0	194.08
194.09	07959	0	19,875	0	0	194.09
200.00						200.00
201.00						201.00
202.00		1,089,388	423,781	2,208,453	1,251,999	202.00
203.00		3.611407	0.171863	22,084.530000	13.021581	203.00
204.00		30,031	72,956	62,429	66,446	204.00
205.00		0.099555	0.029587	624.290000	0.691080	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151315

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

Worksheet C
Part I
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	Hospital			
					RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,376,560		4,376,560	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	94,671		94,671	0	0	31.00
43.00	04300	NURSERY	160,871		160,871	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,113,016		3,113,016	0	0	50.00
51.00	05100	RECOVERY ROOM	1,311,888		1,311,888	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	869,567		869,567	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,703,928		4,703,928	0	0	54.00
60.00	06000	LABORATORY	3,928,726		3,928,726	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	821,979	0	821,979	0	0	65.00
65.01	06501	SLEEP LAB	338,860	0	338,860	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,529,880	0	1,529,880	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	384,362		384,362	0	0	69.00
69.01	06901	CARDIAC REHAB	256,495		256,495	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,138,840		1,138,840	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	626,862		626,862	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,208,453		2,208,453	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	471,161		471,161	0	0	76.00
76.01	03021	ONCOLOGY	2,627,442		2,627,442	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	274,673		274,673	0	0	90.00
91.00	09100	EMERGENCY	3,741,880		3,741,880	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	355,395		355,395	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,509,005		1,509,005		0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
116.00	11600	HOSPICE	274,448		274,448		0	116.00
200.00		Subtotal (see instructions)	35,118,962	0	35,118,962	0	0	200.00
201.00		Less Observation Beds	355,395		355,395		0	201.00
202.00		Total (see instructions)	34,763,567	0	34,763,567	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151315

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

Worksheet C
Part I
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII		Hospital			Cost		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,902,443		4,902,443		30.00
31.00	03100	INTENSIVE CARE UNIT	124,093		124,093		31.00
43.00	04300	NURSERY	251,756		251,756		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,240,312	6,553,025	7,793,337	0.399446	50.00
51.00	05100	RECOVERY ROOM	245,872	1,555,095	1,800,967	0.728435	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	322,290	132,102	454,392	1.913693	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	764,479	19,815,911	20,580,390	0.228564	54.00
60.00	06000	LABORATORY	924,126	9,762,375	10,686,501	0.367634	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	685,524	496,241	1,181,765	0.695552	65.00
65.01	06501	SLEEP LAB	0	704,300	704,300	0.481130	65.01
66.00	06600	PHYSICAL THERAPY	536,771	1,693,815	2,230,586	0.685865	66.00
69.00	06900	ELECTROCARDIOLOGY	103,876	1,015,713	1,119,589	0.343306	69.00
69.01	06901	CARDIAC REHAB	5,012	188,052	193,064	1.328549	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	724,673	1,492,836	2,217,509	0.513567	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	369,664	341,343	711,007	0.881654	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	955,383	3,429,604	4,384,987	0.503640	73.00
76.00	03020	CHEMICAL DEPENDENCY	600	185,090	185,690	2.537353	76.00
76.01	03021	ONCOLOGY	0	4,455,009	4,455,009	0.589773	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	139	370,476	370,615	0.741128	90.00
91.00	09100	EMERGENCY	254,236	10,534,687	10,788,923	0.346826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	282,769	106,561	389,330	0.912837	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	865,461	865,461		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW - SNF					114.00
116.00	11600	HOSPICE	0	553,807	553,807		116.00
200.00		Subtotal (see instructions)	12,694,018	64,251,503	76,945,521		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	12,694,018	64,251,503	76,945,521		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/25/2013 10:02 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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
65.01	06501 SLEEP LAB	0.000000		65.01
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901 CARDIAC REHAB	0.000000		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020 CHEMICAL DEPENDENCY	0.000000		76.00
76.01	03021 ONCOLOGY	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW - SNF			114.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151315

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

Worksheet C
Part I
Date/Time Prepared:
2/25/2013 10:02 am

		Title XIX		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		4,376,560	0	4,376,560	30.00
31.00	03100	INTENSIVE CARE UNIT		94,671	0	94,671	31.00
43.00	04300	NURSERY		160,871	0	160,871	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		3,113,016	0	3,113,016	50.00
51.00	05100	RECOVERY ROOM		1,311,888	0	1,311,888	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		869,567	0	869,567	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		4,703,928	0	4,703,928	54.00
60.00	06000	LABORATORY		3,928,726	0	3,928,726	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	821,979	0	821,979	65.00
65.01	06501	SLEEP LAB	0	338,860	0	338,860	65.01
66.00	06600	PHYSICAL THERAPY	0	1,529,880	0	1,529,880	66.00
69.00	06900	ELECTROCARDIOLOGY		384,362	0	384,362	69.00
69.01	06901	CARDIAC REHAB		256,495	0	256,495	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,138,840	0	1,138,840	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		626,862	0	626,862	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		2,208,453	0	2,208,453	73.00
76.00	03020	CHEMICAL DEPENDENCY		471,161	0	471,161	76.00
76.01	03021	ONCOLOGY		2,627,442	0	2,627,442	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	09000	CLINIC		274,673	0	274,673	90.00
91.00	09100	EMERGENCY		3,741,880	0	3,741,880	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		355,395	0	355,395	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY		1,509,005		1,509,005	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW - SNF					114.00
116.00	11600	HOSPICE		274,448		274,448	116.00
200.00		Subtotal (see instructions)	0	35,118,962	0	35,118,962	200.00
201.00		Less Observation Beds		355,395		355,395	201.00
202.00		Total (see instructions)	0	34,763,567	0	34,763,567	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151315

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

Worksheet C
Part I
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX		Hospital			PPS		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,902,443		4,902,443		30.00
31.00	03100	INTENSIVE CARE UNIT	124,093		124,093		31.00
43.00	04300	NURSERY	251,756		251,756		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,240,312	6,553,025	7,793,337	0.399446	50.00
51.00	05100	RECOVERY ROOM	245,872	1,555,095	1,800,967	0.728435	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	322,290	132,102	454,392	1.913693	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	764,479	19,815,911	20,580,390	0.228564	54.00
60.00	06000	LABORATORY	924,126	9,762,375	10,686,501	0.367634	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	685,524	496,241	1,181,765	0.695552	65.00
65.01	06501	SLEEP LAB	0	704,300	704,300	0.481130	65.01
66.00	06600	PHYSICAL THERAPY	536,771	1,693,815	2,230,586	0.685865	66.00
69.00	06900	ELECTROCARDIOLOGY	103,876	1,015,713	1,119,589	0.343306	69.00
69.01	06901	CARDIAC REHAB	5,012	188,052	193,064	1.328549	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	724,673	1,492,836	2,217,509	0.513567	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	369,664	341,343	711,007	0.881654	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	955,383	3,429,604	4,384,987	0.503640	73.00
76.00	03020	CHEMICAL DEPENDENCY	600	185,090	185,690	2.537353	76.00
76.01	03021	ONCOLOGY	0	4,455,009	4,455,009	0.589773	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	139	370,476	370,615	0.741128	90.00
91.00	09100	EMERGENCY	254,236	10,534,687	10,788,923	0.346826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	282,769	106,561	389,330	0.912837	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	865,461	865,461		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW - SNF					114.00
116.00	11600	HOSPICE	0	553,807	553,807		116.00
200.00		Subtotal (see instructions)	12,694,018	64,251,503	76,945,521		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	12,694,018	64,251,503	76,945,521		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/25/2013 10:02 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.399446	50.00
51.00	05100	RECOVERY ROOM	0.728435	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.913693	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.228564	54.00
60.00	06000	LABORATORY	0.367634	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.695552	65.00
65.01	06501	SLEEP LAB	0.481130	65.01
66.00	06600	PHYSICAL THERAPY	0.685865	66.00
69.00	06900	ELECTROCARDIOLOGY	0.343306	69.00
69.01	06901	CARDIAC REHAB	1.328549	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.513567	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.881654	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.503640	73.00
76.00	03020	CHEMICAL DEPENDENCY	2.537353	76.00
76.01	03021	ONCOLOGY	0.589773	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
90.00	09000	CLINIC	0.741128	90.00
91.00	09100	EMERGENCY	0.346826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.912837	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW - SNF		114.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 151315

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

Worksheet C Part II Date/Time Prepared: 2/25/2013 10:02 am

Cost Center Description		Title XIX			Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,113,016	356,892	2,756,124	0	0	50.00
51.00	05100	RECOVERY ROOM	1,311,888	92,369	1,219,519	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	869,567	93,061	776,506	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,703,928	281,593	4,422,335	0	0	54.00
60.00	06000	LABORATORY	3,928,726	196,895	3,731,831	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	821,979	39,638	782,341	0	0	65.00
65.01	06501	SLEEP LAB	338,860	58,359	280,501	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,529,880	160,637	1,369,243	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	384,362	11,993	372,369	0	0	69.00
69.01	06901	CARDIAC REHAB	256,495	61,812	194,683	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,138,840	35,590	1,103,250	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	626,862	19,589	607,273	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,208,453	62,429	2,146,024	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	471,161	87,479	383,682	0	0	76.00
76.01	03021	ONCOLOGY	2,627,442	388,411	2,239,031	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	274,673	12,658	262,015	0	0	90.00
91.00	09100	EMERGENCY	3,741,880	255,916	3,485,964	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	355,395	0	355,395	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,509,005	68,675	1,440,330	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
116.00	11600	HOSPICE	274,448	13,191	261,257	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	30,486,860	2,297,187	28,189,673	0	0	200.00
201.00		Less Observation Beds	355,395	0	355,395	0	0	201.00
202.00		Total (line 200 minus line 201)	30,131,465	2,297,187	27,834,278	0	0	202.00

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

Provider CCN: 151315

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

Worksheet C
Part II
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3,113,016	7,793,337	0.399446		50.00
51.00	05100 RECOVERY ROOM	1,311,888	1,800,967	0.728435		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	869,567	454,392	1.913693		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,703,928	20,580,390	0.228564		54.00
60.00	06000 LABORATORY	3,928,726	10,686,501	0.367634		60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	821,979	1,181,765	0.695552		65.00
65.01	06501 SLEEP LAB	338,860	704,300	0.481130		65.01
66.00	06600 PHYSICAL THERAPY	1,529,880	2,230,586	0.685865		66.00
69.00	06900 ELECTROCARDIOLOGY	384,362	1,119,589	0.343306		69.00
69.01	06901 CARDIAC REHAB	256,495	193,064	1.328549		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,138,840	2,217,509	0.513567		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	626,862	711,007	0.881654		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,208,453	4,384,987	0.503640		73.00
76.00	03020 CHEMICAL DEPENDENCY	471,161	185,690	2.537353		76.00
76.01	03021 ONCOLOGY	2,627,442	4,455,009	0.589773		76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	09000 CLINIC	274,673	370,615	0.741128		90.00
91.00	09100 EMERGENCY	3,741,880	10,788,923	0.346826		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	355,395	389,330	0.912837		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1,509,005	865,461	1.743585		101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
114.00	11400 UTILIZATION REVIEW - SNF					114.00
116.00	11600 HOSPICE	274,448	553,807	0.495566		116.00
200.00	Subtotal (sum of lines 50 thru 199)	30,486,860	71,667,229			200.00
201.00	Less Observation Beds	355,395	0			201.00
202.00	Total (Line 200 minus Line 201)	30,131,465	71,667,229			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part II Date/Time Prepared: 2/25/2013 10:02 am
--	--	----------------------	---	---

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	356,892	7,793,337	0.045795	330,275	15,125	50.00
51.00	05100	RECOVERY ROOM	92,369	1,800,967	0.051289	60,737	3,115	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	93,061	454,392	0.204803	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	281,593	20,580,390	0.013683	400,856	5,485	54.00
60.00	06000	LABORATORY	196,895	10,686,501	0.018425	378,444	6,973	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	39,638	1,181,765	0.033541	344,177	11,544	65.00
65.01	06501	SLEEP LAB	58,359	704,300	0.082861	0	0	65.01
66.00	06600	PHYSICAL THERAPY	160,637	2,230,586	0.072016	120,376	8,669	66.00
69.00	06900	ELECTROCARDIOLOGY	11,993	1,119,589	0.010712	87,957	942	69.00
69.01	06901	CARDIAC REHAB	61,812	193,064	0.320163	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,590	2,217,509	0.016050	255,996	4,109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,589	711,007	0.027551	97,730	2,693	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,429	4,384,987	0.014237	307,488	4,378	73.00
76.00	03020	CHEMICAL DEPENDENCY	87,479	185,690	0.471102	0	0	76.00
76.01	03021	ONCOLOGY	388,411	4,455,009	0.087185	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	12,658	370,615	0.034154	0	0	90.00
91.00	09100	EMERGENCY	255,916	10,788,923	0.023720	1,408	33	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	389,330	0.000000	17,557	0	92.00
200.00		Total (lines 50-199)	2,215,321	70,247,961		2,403,001	63,066	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315

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

Worksheet D
Part IV
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		Title XVIII				Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
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	
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00	
76.01	03021	ONCOLOGY	0	0	0	0	0	76.01	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
90.00	09000	CLINIC	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
200.00		Total (lines 50-199)	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315

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

Worksheet D
Part IV
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	7,793,337	0.000000	0.000000	330,275	50.00
51.00	05100	RECOVERY ROOM	0	1,800,967	0.000000	0.000000	60,737	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	454,392	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,580,390	0.000000	0.000000	400,856	54.00
60.00	06000	LABORATORY	0	10,686,501	0.000000	0.000000	378,444	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,181,765	0.000000	0.000000	344,177	65.00
65.01	06501	SLEEP LAB	0	704,300	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	2,230,586	0.000000	0.000000	120,376	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,119,589	0.000000	0.000000	87,957	69.00
69.01	06901	CARDIAC REHAB	0	193,064	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,217,509	0.000000	0.000000	255,996	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	711,007	0.000000	0.000000	97,730	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,384,987	0.000000	0.000000	307,488	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	185,690	0.000000	0.000000	0	76.00
76.01	03021	ONCOLOGY	0	4,455,009	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	370,615	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	10,788,923	0.000000	0.000000	1,408	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	389,330	0.000000	0.000000	17,557	92.00
200.00		Total (lines 50-199)	0	70,247,961			2,403,001	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315

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

Worksheet D
Part IV
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		Title XVIII			Hospital	Cost	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
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
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	76.00
76.01	03021	ONCOLOGY	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315

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

Worksheet D
Part IV
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
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
65.01	06501	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0		76.00
76.01	03021	ONCOLOGY	0	0		76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (Lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151315

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

Worksheet D
Part V
Date/Time Prepared:
2/25/2013 10:02 am

		Title XVIII		Hospital		Cost		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges					
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		1.00	2.00	3.00	4.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0.399446	0	1,720,235	0		50.00	
51.00	05100 RECOVERY ROOM	0.728435	0	338,378	0		51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.913693	0	0	0		52.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.228564	0	4,850,772	0		54.00	
60.00	06000 LABORATORY	0.367634	0	3,056,470	0		60.00	
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0		64.00	
65.00	06500 RESPIRATORY THERAPY	0.695552	0	298,127	0		65.00	
65.01	06501 SLEEP LAB	0.481130	0	1,743	0		65.01	
66.00	06600 PHYSICAL THERAPY	0.685865	0	682,201	0		66.00	
69.00	06900 ELECTROCARDIOLOGY	0.343306	0	345,224	0		69.00	
69.01	06901 CARDIAC REHAB	1.328549	0	74,670	0		69.01	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.513567	0	335,837	0		71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.881654	0	115,707	0		72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.503640	0	1,062,997	9,551		73.00	
76.00	03020 CHEMICAL DEPENDENCY	2.537353	0	0	0		76.00	
76.01	03021 ONCOLOGY	0.589773	0	1,661,984	0		76.01	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800 RURAL HEALTH CLINIC	0.000000					88.00	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00	
90.00	09000 CLINIC	0.741128	0	140,090	0		90.00	
91.00	09100 EMERGENCY	0.346826	0	2,349,023	0		91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.912837	0	430,124	0		92.00	
200.00	Subtotal (see instructions)		0	17,463,582	9,551		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	17,463,582	9,551		202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/25/2013 10:02 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			Hospital	Cost	
	PPS Services (see inst.)	Cost	Cost			
		Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
5.00	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	687,141	0	50.00
51.00	05100	RECOVERY ROOM	0	246,486	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,108,712	0	54.00
60.00	06000	LABORATORY	0	1,123,662	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	207,363	0	65.00
65.01	06501	SLEEP LAB	0	839	0	65.01
66.00	06600	PHYSICAL THERAPY	0	467,898	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	118,517	0	69.00
69.01	06901	CARDIAC REHAB	0	99,203	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	172,475	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	102,014	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	535,368	4,810	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	76.00
76.01	03021	ONCOLOGY	0	980,193	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	103,825	0	90.00
91.00	09100	EMERGENCY	0	814,702	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	392,633	0	92.00
200.00		Subtotal (see instructions)	0	7,161,031	4,810	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	7,161,031	4,810	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151315 Component CCN: 15Z315	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/25/2013 10:02 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.399446	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.728435	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1.913693	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.228564	0	0	0	54.00
60.00 06000 LABORATORY	0.367634	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.695552	0	0	0	65.00
65.01 06501 SLEEP LAB	0.481130	0	0	0	65.01
66.00 06600 PHYSICAL THERAPY	0.685865	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.343306	0	0	0	69.00
69.01 06901 CARDIAC REHAB	1.328549	0	0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.513567	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.881654	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.503640	0	0	0	73.00
76.00 03020 CHEMICAL DEPENDENCY	2.537353	0	0	0	76.00
76.01 03021 ONCOLOGY	0.589773	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00 09000 CLINIC	0.741128	0	0	0	90.00
91.00 09100 EMERGENCY	0.346826	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.912837	0	0	0	92.00
200.00 Subtotal (see instructions)		0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151315 Component CCN: 15Z315	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/25/2013 10:02 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs			
	PPS Services (see inst.)	Cost	Cost	
		Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00 06000 LABORATORY	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
65.01 06501 SLEEP LAB	0	0	0	65.01
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
69.01 06901 CARDIAC REHAB	0	0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00 03020 CHEMICAL DEPENDENCY	0	0	0	76.00
76.01 03021 ONCOLOGY	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00 Subtotal (see instructions)	0	0	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	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151315

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

Worksheet D
Part I
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		Title XIX			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	494,601	55,203	439,398	2,953	148.80	30.00
31.00	03100 INTENSIVE CARE UNIT	19,927		19,927	49	406.67	31.00
43.00	04300 NURSERY	17,720		17,720	321	55.20	43.00
200.00	Total (lines 30-199)	532,248		477,045	3,323		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part I Date/Time Prepared: 2/25/2013 10:02 am
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
			6.00	7.00	
Title XIX Hospital PPS					
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	310	46,128	30.00
31.00	03100	INTENSIVE CARE UNIT	3	1,220	31.00
43.00	04300	NURSERY	210	11,592	43.00
200.00		Total (lines 30-199)	523	58,940	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part II Date/Time Prepared: 2/25/2013 10:02 am
--	--	----------------------	---	---

Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	356,892	7,793,337	0.045795	181,497	8,312	50.00
51.00	05100	RECOVERY ROOM	92,369	1,800,967	0.051289	29,249	1,500	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	93,061	454,392	0.204803	38,340	7,852	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	281,593	20,580,390	0.013683	90,943	1,244	54.00
60.00	06000	LABORATORY	196,895	10,686,501	0.018425	109,935	2,026	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	39,638	1,181,765	0.033541	81,550	2,735	65.00
65.01	06501	SLEEP LAB	58,359	704,300	0.082861	0	0	65.01
66.00	06600	PHYSICAL THERAPY	160,637	2,230,586	0.072016	63,855	4,599	66.00
69.00	06900	ELECTROCARDIOLOGY	11,993	1,119,589	0.010712	12,357	132	69.00
69.01	06901	CARDIAC REHAB	61,812	193,064	0.320163	596	191	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,590	2,217,509	0.016050	86,208	1,384	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,589	711,007	0.027551	43,975	1,212	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,429	4,384,987	0.014237	113,653	1,618	73.00
76.00	03020	CHEMICAL DEPENDENCY	87,479	185,690	0.471102	71	33	76.00
76.01	03021	ONCOLOGY	388,411	4,455,009	0.087185	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	12,658	370,615	0.034154	17	1	90.00
91.00	09100	EMERGENCY	255,916	10,788,923	0.023720	30,244	717	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	45,558	389,330	0.117016	33,638	3,936	92.00
200.00		Total (lines 50-199)	2,260,879	70,247,961		916,128	37,492	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315

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

Worksheet D
Part III
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description			Title XIX			Hospital	PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 151315		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/25/2013 10:02 am	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	PPS
			6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,953	0.00	310	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	49	0.00	3	0	0	31.00
43.00	04300	NURSERY	321	0.00	210	0	0	43.00
200.00		Total (lines 30-199)	3,323		523	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151315		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/25/2013 10:02 am	
Cost Center Description		PSA Adj . Allied Health Cost	PSA Adj . All Other Medical Education Cost	Title XIX	Hospital	PPS	
		12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	0			31.00
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: 151315

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

Worksheet D
Part IV
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		Title XIX				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
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
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	76.00
76.01	03021	ONCOLOGY	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315

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

Worksheet D
Part IV
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	7,793,337	0.000000	0.000000	181,497	50.00
51.00	05100	RECOVERY ROOM	0	1,800,967	0.000000	0.000000	29,249	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	454,392	0.000000	0.000000	38,340	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,580,390	0.000000	0.000000	90,943	54.00
60.00	06000	LABORATORY	0	10,686,501	0.000000	0.000000	109,935	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,181,765	0.000000	0.000000	81,550	65.00
65.01	06501	SLEEP LAB	0	704,300	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	2,230,586	0.000000	0.000000	63,855	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,119,589	0.000000	0.000000	12,357	69.00
69.01	06901	CARDIAC REHAB	0	193,064	0.000000	0.000000	596	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,217,509	0.000000	0.000000	86,208	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	711,007	0.000000	0.000000	43,975	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,384,987	0.000000	0.000000	113,653	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	185,690	0.000000	0.000000	71	76.00
76.01	03021	ONCOLOGY	0	4,455,009	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	370,615	0.000000	0.000000	17	90.00
91.00	09100	EMERGENCY	0	10,788,923	0.000000	0.000000	30,244	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	389,330	0.000000	0.000000	33,638	92.00
200.00		Total (lines 50-199)	0	70,247,961			916,128	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315

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

Worksheet D
Part IV
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		Title XIX			Hospital	PPS	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
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
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	76.00
76.01	03021	ONCOLOGY	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315

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

Worksheet D
Part IV
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	Title XIX	Hospital	PPS
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
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
65.01	06501	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0		76.00
76.01	03021	ONCOLOGY	0	0		76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (Lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/25/2013 10:02 am
	Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			1.00	2.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.399446	0	809,222	0	50.00
51.00	05100 RECOVERY ROOM	0.728435	0	166,033	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.913693	0	14,104	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.228564	0	2,115,682	0	54.00
60.00	06000 LABORATORY	0.367634	0	1,042,298	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.695552	0	52,982	0	65.00
65.01	06501 SLEEP LAB	0.481130	0	75,196	0	65.01
66.00	06600 PHYSICAL THERAPY	0.685865	0	180,843	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.343306	0	108,444	0	69.00
69.01	06901 CARDIAC REHAB	1.328549	0	20,078	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.513567	0	159,385	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.881654	0	36,444	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.503640	0	366,168	0	73.00
76.00	03020 CHEMICAL DEPENDENCY	2.537353	0	19,761	0	76.00
76.01	03021 ONCOLOGY	0.589773	0	475,647	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	09000 CLINIC	0.741128	0	39,555	0	90.00
91.00	09100 EMERGENCY	0.346826	0	1,124,755	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.912837	0	11,377	0	92.00
200.00	Subtotal (see instructions)		0	6,817,974	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	6,817,974	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/25/2013 10:02 am
	Title XIX	Hospital	PPS

Cost Center Description	Costs			Hospital	PPS	
	PPS Services (see inst.)	Cost	Cost			
		Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
5.00	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	323,240	0	50.00
51.00	05100	RECOVERY ROOM	0	120,944	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	26,991	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	483,569	0	54.00
60.00	06000	LABORATORY	0	383,184	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	36,852	0	65.00
65.01	06501	SLEEP LAB	0	36,179	0	65.01
66.00	06600	PHYSICAL THERAPY	0	124,034	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	37,229	0	69.00
69.01	06901	CARDIAC REHAB	0	26,675	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	81,855	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	32,131	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	184,417	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	50,141	0	76.00
76.01	03021	ONCOLOGY	0	280,524	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	29,315	0	90.00
91.00	09100	EMERGENCY	0	390,094	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	10,385	0	92.00
200.00		Subtotal (see instructions)	0	2,657,759	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	2,657,759	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 2/25/2013 10:02 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,558	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,953	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,681	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)		371	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)		234	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,105	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)		371	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		138.74	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		142.90	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,376,560	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)		33,439	25.00
26.00	Total swing-bed cost (see instructions)		518,184	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,858,376	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		4,494,239	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		4,494,239	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.858516	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,676.33	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,858,376	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,306.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,443,782	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)		1,443,782	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151315		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/25/2013 10:02 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	94,671	49	1,932.06	24	46,369	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,148,084	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,638,235	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					484,745	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					484,745	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					272	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,306.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					355,395	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151315		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/25/2013 10:02 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 2/25/2013 10:02 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,558	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,953	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,681	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)		371	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)		234	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		310	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)		321	15.00
16.00	Nursery days (title V or XIX only)		210	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,376,560	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)		488,477	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,888,083	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		4,494,239	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		4,494,239	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.865126	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,676.33	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,888,083	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,316.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		408,165	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)		408,165	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151315		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/25/2013 10:02 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
NURSERY (title V & XIX only)		160,871	321	501.16	210	105,244	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	94,671	49	1,932.06	3	5,796	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					515,602	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,034,807	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					58,940	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					37,492	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					96,432	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					938,375	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					272	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,316.66	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					358,132	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151315		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/25/2013 10:02 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	494,601	3,888,083	0.127209	358,132	45,558	90.00
91.00	Nursing School cost	0	3,888,083	0.000000	358,132	0	91.00
92.00	Allied health cost	0	3,888,083	0.000000	358,132	0	92.00
93.00	All other Medical Education	0	3,888,083	0.000000	358,132	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/25/2013 10:02 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,374,795	30.00
31.00	03100	INTENSIVE CARE UNIT		56,019	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.399446	330,275	131,927 50.00
51.00	05100	RECOVERY ROOM	0.728435	60,737	44,243 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.913693	0	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.228564	400,856	91,621 54.00
60.00	06000	LABORATORY	0.367634	378,444	139,129 60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.695552	344,177	239,393 65.00
65.01	06501	SLEEP LAB	0.481130	0	0 65.01
66.00	06600	PHYSICAL THERAPY	0.685865	120,376	82,562 66.00
69.00	06900	ELECTROCARDIOLOGY	0.343306	87,957	30,196 69.00
69.01	06901	CARDIAC REHAB	1.328549	0	0 69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.513567	255,996	131,471 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.881654	97,730	86,164 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.503640	307,488	154,863 73.00
76.00	03020	CHEMICAL DEPENDENCY	2.537353	0	0 76.00
76.01	03021	ONCOLOGY	0.589773	0	0 76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
90.00	09000	CLINIC	0.741128	0	0 90.00
91.00	09100	EMERGENCY	0.346826	1,408	488 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.912837	17,557	16,027 92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,403,001	1,148,084 200.00
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)		2,403,001	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3	
		Component CCN: 15Z315		Date/Time Prepared: 2/25/2013 10:02 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.399446	344	137 50.00
51.00	05100	RECOVERY ROOM	0.728435	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.913693	0	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.228564	18,981	4,338 54.00
60.00	06000	LABORATORY	0.367634	31,396	11,542 60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.695552	22,282	15,498 65.00
65.01	06501	SLEEP LAB	0.481130	0	0 65.01
66.00	06600	PHYSICAL THERAPY	0.685865	198,874	136,401 66.00
69.00	06900	ELECTROCARDIOLOGY	0.343306	217	74 69.00
69.01	06901	CARDIAC REHAB	1.328549	0	0 69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.513567	14,061	7,221 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.881654	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.503640	46,928	23,635 73.00
76.00	03020	CHEMICAL DEPENDENCY	2.537353	0	0 76.00
76.01	03021	ONCOLOGY	0.589773	0	0 76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
90.00	09000	CLINIC	0.741128	0	0 90.00
91.00	09100	EMERGENCY	0.346826	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.912837	0	0 92.00
200.00		Total (sum of lines 50-94 and 96-98)		333,083	198,846 200.00
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)		333,083	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/25/2013 10:02 am	
Cost Center Description		Title XIX	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		583,197	30.00
31.00	03100	INTENSIVE CARE UNIT		14,762	31.00
43.00	04300	NURSERY		29,949	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.399446	181,497	50.00
51.00	05100	RECOVERY ROOM	0.728435	29,249	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.913693	38,340	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.228564	90,943	54.00
60.00	06000	LABORATORY	0.367634	109,935	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.695552	81,550	65.00
65.01	06501	SLEEP LAB	0.481130	0	65.01
66.00	06600	PHYSICAL THERAPY	0.685865	63,855	66.00
69.00	06900	ELECTROCARDIOLOGY	0.343306	12,357	69.00
69.01	06901	CARDIAC REHAB	1.328549	596	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.513567	86,208	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.881654	43,975	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.503640	113,653	73.00
76.00	03020	CHEMICAL DEPENDENCY	2.537353	71	76.00
76.01	03021	ONCOLOGY	0.589773	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.741128	17	90.00
91.00	09100	EMERGENCY	0.346826	30,244	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.912837	33,638	92.00
200.00		Total (sum of lines 50-94 and 96-98)		916,128	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)		916,128	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/25/2013 10:02 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			7,165,841 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			7,165,841 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			7,237,499 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)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			28,878 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,876,579 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)			4,332,042 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)			4,332,042 30.00
31.00	Primary payer payments			2,937 31.00
32.00	Subtotal (line 30 minus line 31)			4,329,105 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			313,430 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			313,430 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			238,538 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			4,642,535 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			4,642,535 40.00
41.00	Interim payments			4,610,924 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)			31,611 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/25/2013 10:02 am
	Title XVIII	Hospital	Cost
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151315

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

Worksheet E-1
Part I
Date/Time Prepared:
2/25/2013 10:02 am

		Title XVIII		Hospital		Cost	
		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		1,889,042		4,670,687	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	04/20/2012	40,146		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0	04/20/2012	59,763	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)		40,146		-59,763	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)		1,929,188		4,610,924	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		498,073		31,611	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,427,261		4,642,535	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151315
Component CCN: 15Z315

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

Worksheet E-1
Part I
Date/Time Prepared:
2/25/2013 10:02 am

Title XVIII Swing Beds - SNF Cost

		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		547,124		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	04/20/2012	4,372		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		4,372		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)		551,496		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		135,224		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		686,720		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 151315

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

Worksheet E-1
Part II
Date/Time Prepared:
2/25/2013 10:02 am

		Title XVIII	Hospital	Cost	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			880	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,129	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			469	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			2,730	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			76,945,521	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			1,048,149	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			676,997	7.00
8.00	Calculation of the HIT incentive payment (see instructions)			537,123	8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			423,394	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			113,729	32.00
				Overrides	
				1.00	
CONTRACTOR OVERRIDES					
108.00	Override of HIT payment				0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151315

Period:

Worksheet E-2

Component CCN: 15Z315

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

Date/Time Prepared:
2/25/2013 10:02 am

		Title XVIII		Swing Beds - SNF	
		Part A	Part B		
		1.00	2.00		
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	489,592	0	1.00	
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00	
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	200,834	0	3.00	
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00	
5.00	Program days	371	0	5.00	
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00	
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00	
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	690,426	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	690,426	0	10.00	
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00	
12.00	Subtotal (line 10 minus line 11)	690,426	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,706	0	13.00	
14.00	80% of Part B costs (line 12 x 80%)		0	14.00	
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	686,720	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00	
17.00	Reimbursable bad debts (see instructions)	0	0	17.00	
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00	
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	686,720	0	19.00	
20.00	Interim payments	551,496	0	20.00	
21.00	Tentative settlement (for contractor use only)	0	0	21.00	
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	135,224	0	22.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2	0	0	23.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151315	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part V Date/Time Prepared: 2/25/2013 10:02 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services		2,638,235	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		2,638,235	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,664,617	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,664,617	19.00
20.00	Deductibles (exclude professional component)		260,708	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		2,403,909	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		2,403,909	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		23,352	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		23,352	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		5,425	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,427,261	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		2,427,261	30.00
31.00	Interim payments		1,929,188	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)		498,073	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

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

Provider CCN: 151315

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

Worksheet G

Date/Time Prepared:
2/25/2013 10:02 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,686,623	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	8,991,401	0	0	0	4.00
5.00	Other receivable	588,887	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,268,593	0	0	0	6.00
7.00	Inventory	1,918,866	0	0	0	7.00
8.00	Prepaid expenses	304,185	0	0	0	8.00
9.00	Other current assets	1,549,345	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)	13,770,714	0	0	0	11.00
FIXED ASSETS						
12.00	Land	8,066,163	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	16,308,754	0	0	0	15.00
16.00	Accumulated depreciation	-11,864,177	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	16,265,257	0	0	0	19.00
20.00	Accumulated depreciation	-12,748,423	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	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	16,027,574	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	13,675,476	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	2,307,787	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	15,983,263	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	45,781,551	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,689,585	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,679,228	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,326,924	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	1,004,822	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,700,559	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	14,378,554	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,378,554	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	20,079,113	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	25,702,438				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	25,702,438	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	45,781,551	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151315

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

Worksheet G-1

Date/Time Prepared:
2/25/2013 10:02 am

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		22,261,179	
2.00	Net income (loss) (From Wkst. G-3, line 29)		3,250,662			2.00
3.00	Total (sum of line 1 and line 2)		25,511,841		0	3.00
4.00	TRANSFERS TO SUBSIDIARIES	190,601		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		190,601		0	10.00
11.00	Subtotal (line 3 plus line 10)		25,702,442		0	11.00
12.00	ROUNDING	4		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		4		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		25,702,438		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151315

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

Worksheet G-1

Date/Time Prepared:
2/25/2013 10:02 am

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151315

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,494,239		4,494,239	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,494,239		4,494,239	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	124,093		124,093	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)	124,093		124,093	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,618,332		4,618,332	17.00
18.00	Ancillary services	7,671,102	64,548,509	72,219,611	18.00
19.00	Outpatient services	0	0	0	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		865,461	865,461	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	553,807	553,807	26.00
27.00	OTHER (SPECIFY)	0	2,236,429	2,236,429	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,289,434	68,204,206	80,493,640	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		45,497,570		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)		45,497,570		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151315

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

Worksheet G-3

Date/Time Prepared:
2/25/2013 10:02 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	80,493,640	1.00
2.00	Less contractual allowances and discounts on patients' accounts	35,453,749	2.00
3.00	Net patient revenues (line 1 minus line 2)	45,039,891	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	45,497,570	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-457,679	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	3,708,341	24.00
25.00	Total other income (sum of lines 6-24)	3,708,341	25.00
26.00	Total (line 5 plus line 25)	3,250,662	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)	3,250,662	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151315
HHA CCN: 157117

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

Worksheet H
Date/Time Prepared:
2/25/2013 10:02 am
PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	1.00
2.00	Capital Related - Movable Equipment			0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	200,511	0	0	-7,626	46,725	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	250,876	0	26,168	0	0	6.00
7.00	Physical Therapy	74,010	0	0	0	0	7.00
8.00	Occupational Therapy	24,257	0	0	0	0	8.00
9.00	Speech Pathology	5,262	0	0	0	0	9.00
10.00	Medical Social Services	18,497	0	0	0	0	10.00
11.00	Home Health Aide	29,046	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	60,834	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	663,293	0	26,168	-7,626	46,725	24.00

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

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151315

Period:

Worksheet H

HHA CCN: 157117

From 10/01/2011

Date/Time Prepared:
2/25/2013 10:02 am

To 09/30/2012
Home Health Agency I

PPS

		Total (sum of col.s. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	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	239,610	0	239,610	0	239,610	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	277,044	0	277,044	0	277,044	6.00
7.00	Physical Therapy	74,010	0	74,010	0	74,010	7.00
8.00	Occupational Therapy	24,257	0	24,257	0	24,257	8.00
9.00	Speech Pathology	5,262	0	5,262	0	5,262	9.00
10.00	Medical Social Services	18,497	0	18,497	0	18,497	10.00
11.00	Home Health Aide	29,046	0	29,046	0	29,046	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	60,834	0	60,834	0	60,834	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	728,560	0	728,560	0	728,560	24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST	Provider CCN: 151315	Period:	Worksheet H-1
	HHA CCN: 157117	From 10/01/2011 To 09/30/2012	Part I Date/Time Prepared: 2/25/2013 10:02 am
		Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
		Bldgs & Fixtures	Movable Equipment			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	239,610	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	277,044	0	0	0	6.00
7.00	Physical Therapy	74,010	0	0	0	7.00
8.00	Occupational Therapy	24,257	0	0	0	8.00
9.00	Speech Pathology	5,262	0	0	0	9.00
10.00	Medical Social Services	18,497	0	0	0	10.00
11.00	Home Health Aide	29,046	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	60,834	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)	728,560	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 151315	Period: From 10/01/2011	Worksheet H-1
		HHA CCN: 157117	To 09/30/2012	Part I
				Date/Time Prepared: 2/25/2013 10:02 am
			Home Health Agency I	PPS

	Subtotal (col s. 0-4) 4A.00	Administrative & General 5.00	Total (col s. 4A + 5) 6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures	0		1.00
2.00	Capital Related - Movable Equipment	0		2.00
3.00	Plant Operations & Maintenance	0		3.00
4.00	Transportation			4.00
5.00	Administrative and General	239,610	239,610	5.00
HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	277,044	135,765	412,809
7.00	Physical Therapy	74,010	36,269	110,279
8.00	Occupational Therapy	24,257	11,887	36,144
9.00	Speech Pathology	5,262	2,579	7,841
10.00	Medical Social Services	18,497	9,064	27,561
11.00	Home Health Aide	29,046	14,234	43,280
12.00	Supplies (see instructions)	0	0	0
13.00	Drugs	0	0	0
14.00	DME	0	0	0
HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0	0
16.00	Respiratory Therapy	0	0	0
17.00	Private Duty Nursing	60,834	29,812	90,646
18.00	Clinic	0	0	0
19.00	Health Promotion Activities	0	0	0
20.00	Day Care Program	0	0	0
21.00	Home Delivered Meals Program	0	0	0
22.00	Homemaker Service	0	0	0
23.00	All Others (specify)	0	0	0
24.00	Total (sum of lines 1-23)	728,560		728,560

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151315
HHA CCN: 157117

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

Worksheet H-1
Part II
Date/Time Prepared:
2/25/2013 10:02 am
PPS

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)				
		1.00	2.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0	0	-239,610	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-239,610	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	0	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS	Provider CCN: 151315	Period:	Worksheet H-1
	HHA CCN: 157117	From 10/01/2011 To 09/30/2012	Part II Date/Time Prepared: 2/25/2013 10:02 am
		Home Health Agency I	PPS

		Administrative & General (ACCUM. COST)	
		5.00	
GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures		1.00
2.00	Capital Related - Movable Equipment		2.00
3.00	Plant Operation & Maintenance		3.00
4.00	Transportation (see instructions)		4.00
5.00	Administrative and General	488,950	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	277,044	6.00
7.00	Physical Therapy	74,010	7.00
8.00	Occupational Therapy	24,257	8.00
9.00	Speech Pathology	5,262	9.00
10.00	Medical Social Services	18,497	10.00
11.00	Home Health Aide	29,046	11.00
12.00	Supplies (see instructions)	0	12.00
13.00	Drugs	0	13.00
14.00	DME	0	14.00
HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	15.00
16.00	Respiratory Therapy	0	16.00
17.00	Private Duty Nursing	60,834	17.00
18.00	Clinic	0	18.00
19.00	Health Promotion Activities	0	19.00
20.00	Day Care Program	0	20.00
21.00	Home Delivered Meals Program	0	21.00
22.00	Homemaker Service	0	22.00
23.00	All Others (specify)	0	23.00
24.00	Total (sum of lines 1-23)	488,950	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	239,610	25.00
26.00	Unit Cost Multiplier	0.490050	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151315
HHA CCN: 157117

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

Worksheet H-2
Part I
Date/Time Prepared:
2/25/2013 10:02 am
PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
	0			4.00	4A	
1.00 Administrative and General	0	13,296	24,112	83,353	120,761	1.00
2.00 Skilled Nursing Care	412,809	0	0	104,291	517,100	2.00
3.00 Physical Therapy	110,279	0	0	30,766	141,045	3.00
4.00 Occupational Therapy	36,144	0	0	10,084	46,228	4.00
5.00 Speech Pathology	7,841	0	0	2,187	10,028	5.00
6.00 Medical Social Services	27,561	0	0	7,689	35,250	6.00
7.00 Home Health Aide	43,280	0	0	12,075	55,355	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	90,646	0	0	25,289	115,935	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)	728,560	13,296	24,112	275,734	1,041,702	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000	21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151315
HHA CCN: 157117

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

Worksheet H-2
Part I
Date/Time Prepared:
2/25/2013 10:02 am
PPS

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	32,699	49,672	0	18,132	0	1.00
2.00	Skilled Nursing Care	140,016	0	0	0	0	2.00
3.00	Physical Therapy	38,191	0	0	0	0	3.00
4.00	Occupational Therapy	12,517	0	0	0	0	4.00
5.00	Speech Pathology	2,715	0	0	0	0	5.00
6.00	Medical Social Services	9,545	0	0	0	0	6.00
7.00	Home Health Aide	14,989	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	31,392	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)	282,064	49,672	0	18,132	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: 151315
HHA CCN: 157117

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

Worksheet H-2
Part I
Date/Time Prepared:
2/25/2013 10:02 am
PPS

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	18,190	0	1,203	0	0	1.00
2.00 Skilled Nursing Care	16,132	31,339	0	0	0	2.00
3.00 Physical Therapy	4,280	4,117	0	0	0	3.00
4.00 Occupational Therapy	1,440	2,662	0	0	0	4.00
5.00 Speech Pathology	288	556	0	0	0	5.00
6.00 Medical Social Services	1,358	2,449	0	0	0	6.00
7.00 Home Health Aide	4,527	20,910	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	7,984	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)	54,199	62,033	1,203	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: 151315
HHA CCN: 157117

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

Worksheet H-2
Part I
Date/Time Prepared:
2/25/2013 10:02 am
PPS

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	240,657	0	240,657			1.00
2.00	Skilled Nursing Care	704,587	0	704,587	133,687	838,274	2.00
3.00	Physical Therapy	187,633	0	187,633	35,602	223,235	3.00
4.00	Occupational Therapy	62,847	0	62,847	11,925	74,772	4.00
5.00	Speech Pathology	13,587	0	13,587	2,578	16,165	5.00
6.00	Medical Social Services	48,602	0	48,602	9,222	57,824	6.00
7.00	Home Health Aide	95,781	0	95,781	18,174	113,955	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	155,311	0	155,311	29,469	184,780	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)	1,509,005	0	1,509,005	240,657	1,509,005	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.				0.189741		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: 151315
HHA CCN: 157117

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

Worksheet H-2
Part II
Date/Time Prepared:
2/25/2013 10:02 am
PPS

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
1.00 Administrative and General	1,387	1,387	200,511	5A	120,761	1.00	
2.00 Skilled Nursing Care	0	0	250,876	0	517,100	2.00	
3.00 Physical Therapy	0	0	74,010	0	141,045	3.00	
4.00 Occupational Therapy	0	0	24,257	0	46,228	4.00	
5.00 Speech Pathology	0	0	5,262	0	10,028	5.00	
6.00 Medical Social Services	0	0	18,497	0	35,250	6.00	
7.00 Home Health Aide	0	0	29,046	0	55,355	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	60,834	0	115,935	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)	1,387	1,387	663,293		1,041,702	20.00	
21.00 Total cost to be allocated	13,296	24,112	275,734		282,064	21.00	
22.00 Unit cost multiplier	9.586157	17.384283	0.415705		0.270772	22.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 151315 HHA CCN: 157117	Period: From 10/01/2011 To 09/30/2012	Worksheet H-2 Part II Date/Time Prepared: 2/25/2013 10:02 am PPS
		Home Health Agency I	

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
	7.00	8.00	9.00	10.00	11.00	
1.00 Administrative and General	1,387	0	15	0	442	1.00
2.00 Skilled Nursing Care	0	0	0	0	392	2.00
3.00 Physical Therapy	0	0	0	0	104	3.00
4.00 Occupational Therapy	0	0	0	0	35	4.00
5.00 Speech Pathology	0	0	0	0	7	5.00
6.00 Medical Social Services	0	0	0	0	33	6.00
7.00 Home Health Aide	0	0	0	0	110	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	194	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)	1,387	0	15	0	1,317	20.00
21.00 Total cost to be allocated	49,672	0	18,132	0	54,199	21.00
22.00 Unit cost multiplier	35.812545	0.000000	1,208.800000	0.000000	41.153379	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151315
HHA CCN: 157117

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

Worksheet H-2
Part II
Date/Time Prepared:
2/25/2013 10:02 am
PPS

Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
	(DIRECT NRSING HRS)	(COSTED REQUIS.)				
	13.00	14.00	15.00	16.00		
1.00 Administrative and General	0	7,000	0	0		1.00
2.00 Skilled Nursing Care	8,678	0	0	0		2.00
3.00 Physical Therapy	1,140	0	0	0		3.00
4.00 Occupational Therapy	737	0	0	0		4.00
5.00 Speech Pathology	154	0	0	0		5.00
6.00 Medical Social Services	678	0	0	0		6.00
7.00 Home Health Aide	5,790	0	0	0		7.00
8.00 Supplies (see instructions)	0	0	0	0		8.00
9.00 Drugs	0	0	0	0		9.00
10.00 DME	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0		13.00
14.00 Clinic	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0		19.00
20.00 Total (sum of lines 1-19)	17,177	7,000	0	0		20.00
21.00 Total cost to be allocated	62,033	1,203	0	0		21.00
22.00 Unit cost multiplier	3.611399	0.171857	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151315 HHA CCN: 157117		Period: From 10/01/2011 To 09/30/2012		Worksheet H-3 Parts I-III Date/Time Prepared: 2/25/2013 10:02 am	
		Title XVIII		Home Health Agency I		PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	838,274		838,274	1,623	1.00
2.00	Physical Therapy	3.00	223,235	0	223,235	1,439	2.00
3.00	Occupational Therapy	4.00	74,772	0	74,772	364	3.00
4.00	Speech Pathology	5.00	16,165	0	16,165	98	4.00
5.00	Medical Social Services	6.00	57,824		57,824	29	5.00
6.00	Home Health Aide	7.00	113,955		113,955	1,188	6.00
7.00	Total (sum of lines 1-6)		1,324,225	0	1,324,225	4,741	7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits		
					Part B		
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	386	333		8.00
9.00	Physical Therapy		99915	454	224		9.00
10.00	Occupational Therapy		99915	86	28		10.00
11.00	Speech Pathology		99915	6	18		11.00
12.00	Medical Social Services		99915	6	8		12.00
13.00	Home Health Aide		99915	181	67		13.00
14.00	Total (sum of lines 8-13)			1,119	678		14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00
Cost Center Description		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)		
		0	1.00	2.00	3.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy		66.00	0.685865	0	0	1.00
2.00	Occupational Therapy						2.00
3.00	Speech Pathology						3.00
4.00	Cost of Medical Supplies		71.00	0.513567	0	0	4.00
5.00	Cost of Drugs		73.00	0.503640	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151315
HHA CCN: 157117

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

Worksheet H-3
Parts I-III
Date/Time Prepared:
2/25/2013 10:02 am
PPS

Title XVIII

Home Health
Agency I

Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Program Visits			
			Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	5.00	6.00	7.00	8.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
Cost Per Visit Computation						
1.00	Skilled Nursing Care	516.50	386	333		1.00
2.00	Physical Therapy	155.13	454	224		2.00
3.00	Occupational Therapy	205.42	86	28		3.00
4.00	Speech Pathology	164.95	6	18		4.00
5.00	Medical Social Services	1,993.93	6	8		5.00
6.00	Home Health Aide	95.92	181	67		6.00
7.00	Total (sum of lines 1-6)		1,119	678		7.00
Cost Center Description						
		5.00	6.00	7.00	8.00	9.00
Limitation Cost Computation						
8.00	Skilled Nursing Care					8.00
9.00	Physical Therapy					9.00
10.00	Occupational Therapy					10.00
11.00	Speech Pathology					11.00
12.00	Medical Social Services					12.00
13.00	Home Health Aide					13.00
14.00	Total (sum of lines 8-13)					14.00
Program Covered Charges						
Cost Center Description	Ratio (col. 3 ÷ col. 4)	Part A	Part B			
			Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	5.00	6.00	7.00	8.00		
Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0.000000				15.00
16.00	Cost of Drugs	0.000000		650	0	16.00
Cost Center Description						
			Transfer to Part I as Indicated			
			4.00			
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	col. 2, line 2.00				1.00
2.00	Occupational Therapy					2.00
3.00	Speech Pathology					3.00
4.00	Cost of Medical Supplies	col. 2, line 15.00				4.00
5.00	Cost of Drugs	col. 2, line 16.00				5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151315
HHA CCN: 157117

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

Worksheet H-3
Parts I-III
Date/Time Prepared:
2/25/2013 10:02 am
PPS

Title XVIII

Home Health Agency I

Cost Center Description	Cost of Services			Total Program Cost (sum of col.s. 9-10)		
	Part A	Part B				
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
	9.00	10.00	11.00	12.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
Cost Per Visit Computation						
1.00	Skilled Nursing Care	199,369	171,995		371,364	1.00
2.00	Physical Therapy	70,429	34,749		105,178	2.00
3.00	Occupational Therapy	17,666	5,752		23,418	3.00
4.00	Speech Pathology	990	2,969		3,959	4.00
5.00	Medical Social Services	11,964	15,951		27,915	5.00
6.00	Home Health Aide	17,362	6,427		23,789	6.00
7.00	Total (sum of lines 1-6)	317,780	237,843		555,623	7.00
Cost Center Description						
		10.00	11.00	12.00		
Limitation Cost Computation						
8.00	Skilled Nursing Care					8.00
9.00	Physical Therapy					9.00
10.00	Occupational Therapy					10.00
11.00	Speech Pathology					11.00
12.00	Medical Social Services					12.00
13.00	Home Health Aide					13.00
14.00	Total (sum of lines 8-13)					14.00
Cost of Services						
Cost Center Description	Part A	Part B				
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
	9.00	10.00	11.00			
Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies					15.00
16.00	Cost of Drugs		0	0		16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151315 HHA CCN: 157117	Period: From 10/01/2011 To 09/30/2012	Worksheet H-4 Part I-II Date/Time Prepared: 2/25/2013 10:02 am
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	2.00
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	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	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	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	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	8.00
9.00	Primary payer amounts	0	0	9.00
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		170,951	104,688
12.00	Total PPS Reimbursement - Full Episodes with Outliers		1,997	0
13.00	Total PPS Reimbursement - LUPA Episodes		1,274	3,254
14.00	Total PPS Reimbursement - PEP Episodes		0	473
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	0
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		174,222	108,415
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		174,222	108,415
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		174,222	108,415
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		174,222	108,415
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		174,222	108,415
32.00	Interim payments (see instructions)		174,222	108,415
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0

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

Provider CCN: 151315
HHA CCN: 157117

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

Worksheet H-5
Date/Time Prepared:
2/25/2013 10:02 am
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		174,222		108,415	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		174,222		108,415	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		174,222		108,415	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151315

Period: From 10/01/2011

Worksheet K

Hospice CCN: 151561

To 09/30/2012

Date/Time Prepared: 2/25/2013 10:02 am

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	28,838	0	0	0	10,871	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	54,995	0	0	15,861	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	25,986	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	15,254	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	407	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	99,087	0	25,986	15,861	11,278	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151315

Period: From 10/01/2011

Worksheet K

Hospice CCN: 151561

To 09/30/2012

Date/Time Prepared: 2/25/2013 10:02 am

		Total (col. 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	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	39,709	0	39,709	0	39,709	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	70,856	0	70,856	0	70,856	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	25,986	0	25,986	0	25,986	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	15,254	0	15,254	0	15,254	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	407	0	407	0	407	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	152,212	0	152,212	0	152,212	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151315
Hospice CCN: 151561

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

Worksheet K-1
Date/Time Prepared:
2/25/2013 10:02 am

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	28,838	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	54,995	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	15,254	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	99,087	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151315
Hospice CCN: 151561

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

Worksheet K-1
Date/Time Prepared:
2/25/2013 10:02 am

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	28,838	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	54,995	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	0	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	15,254	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	99,087	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES		Provider CCN: 151315	Period:	Worksheet K-3
		Hospice CCN: 151561	From 10/01/2011 To 09/30/2012	Date/Time Prepared: 2/25/2013 10:02 am

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	15,861	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	15,861	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES		Provider CCN: 151315	Period:	Worksheet K-3
		Hospice CCN: 151561	From 10/01/2011 To 09/30/2012	Date/Time Prepared: 2/25/2013 10:02 am

		Total Therapists	Aides	All-Other	Hospice I Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	0	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	15,861	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	0	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	0	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	15,861	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151315
 Hospice CCN: 151561

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

Worksheet K-4
 Part I
 Date/Time Prepared:
 2/25/2013 10:02 am

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	39,709	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	70,856	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	25,986	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	15,254	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	407	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	152,212	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151315
 Hospice CCN: 151561

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

Worksheet K-4
 Part I
 Date/Time Prepared:
 2/25/2013 10:02 am

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col . 5A ± col . 6)	
		5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance					3.00
4.00	Transportation - Staff					4.00
5.00	Volunteer Service Coordination	0				5.00
6.00	Administrative and General	0	39,709	39,709		6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	70,856	25,009	95,865	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	0	25,986	9,172	35,158	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	0	15,254	5,384	20,638	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	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	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	407	144	551	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	152,212		152,212	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151315
 Hospice CCN: 151561

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

Worksheet K-4
 Part II
 Date/Time Prepared:
 2/25/2013 10:02 am

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151315
Hospice CCN: 151561

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

Worksheet K-4
Part II
Date/Time Prepared:
2/25/2013 10:02 am

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	Hospice I
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-39,709	112,503	6.00
INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	70,856	7.00
8.00	Inpatient - Respite Care	0	0	8.00
VISITING SERVICES				
9.00	Physician Services	0	0	9.00
10.00	Nursing Care	0	25,986	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	0	12.00
13.00	Occupational Therapy	0	0	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	15,254	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	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	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	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	407	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		39,709	39.00
40.00	Unit Cost Multiplier		0.352959	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151315
Hospice CCN: 151561

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

Worksheet K-5
Part I
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
	0			4.00	4A	
1.00 Administrative and General		2,723	4,937	11,988	19,648	1.00
2.00 Inpatient - General Care	95,865	0	0	22,862	118,727	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	35,158	0	0	0	35,158	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	20,638	0	0	6,341	26,979	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	551	0	0	0	551	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)	152,212	2,723	4,937	41,191	201,063	34.00
35.00 Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151315

Period:

Worksheet K-5

Hospice CCN: 151561

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

Part I
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		Hospice I					
		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
1.00	Administrative and General	5,320	10,171	0	0	0	1.00
2.00	Inpatient - General Care	32,148	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	9,520	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	7,305	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	149	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)	54,442	10,171	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: 151315

Period: From 10/01/2011

Worksheet K-5

Hospice CCN: 151561

To 09/30/2012

Part I
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description	Hospice I					
	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	8,478	0	294	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)	8,478	0	294	0	0	34.00
35.00 Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151315

Period:

Worksheet K-5

Hospice CCN: 151561

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

Part I
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		Hospice I					
		Subtotal (col.s. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (col.s. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (col.s. 26 ± 27)	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	43,911					1.00
2.00	Inpatient - General Care	150,875	0	150,875	28,738	179,613	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	44,678	0	44,678	8,510	53,188	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	34,284	0	34,284	6,530	40,814	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	700	0	700	133	833	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)	274,448	0	274,448		274,448	34.00
35.00	Unit Cost Multiplier (see instructions)				0.190473		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151315
Hospice CCN: 151561

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

Worksheet K-5
Part II
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00				
1.00	Administrative and General	284	284	28,838	0	19,648	1.00
2.00	Inpatient - General Care	0	0	54,995	0	118,727	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	35,158	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	15,254	0	26,979	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	551	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)	284	284	99,087		201,063	34.00
35.00	Total cost to be allocated	2,723	4,937	41,191		54,442	35.00
36.00	Unit Cost Multiplier (see instructions)	9.588028	17.383803	0.415705		0.270771	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151315
Hospice CCN: 151561

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

Worksheet K-5
Part II
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description	Hospice I					CAFETERIA (FTES)	
	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)			
	7.00	8.00	9.00	10.00	11.00		
1.00 Administrative and General	284	0	0	0	0	206	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)	284	0	0	0	0	206	34.00
35.00 Total cost to be allocated	10,171	0	0	0	0	8,478	35.00
36.00 Unit Cost Multiplier (see instructions)	35.813380	0.000000	0.000000	0.000000	0.000000	41.155340	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151315
Hospice CCN: 151561

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

Worksheet K-5
Part II
Date/Time Prepared:
2/25/2013 10:02 am

Cost Center Description	Hospice I					
	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY		
	(DIRECT NURSING HRS)	(COSTED REQUIS.)		(TIME SPENT)		
	13.00	14.00	15.00	16.00		
1.00 Administrative and General	0	1,711	0	0		1.00
2.00 Inpatient - General Care	0	0	0	0		2.00
3.00 Inpatient - Respite Care	0	0	0	0		3.00
4.00 Physician Services	0	0	0	0		4.00
5.00 Nursing Care	0	0	0	0		5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00 Physical Therapy	0	0	0	0		7.00
8.00 Occupational Therapy	0	0	0	0		8.00
9.00 Speech/ Language Pathology	0	0	0	0		9.00
10.00 Medical Social Services	0	0	0	0		10.00
11.00 Spiritual Counseling	0	0	0	0		11.00
12.00 Dietary Counseling	0	0	0	0		12.00
13.00 Counseling - Other	0	0	0	0		13.00
14.00 Home Health Aide and Homemaker	0	0	0	0		14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00 Other	0	0	0	0		16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00 Analgesics	0	0	0	0		18.00
19.00 Sedatives / Hypnotics	0	0	0	0		19.00
20.00 Other - Specify	0	0	0	0		20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00 Patient Transportation	0	0	0	0		22.00
23.00 Imaging Services	0	0	0	0		23.00
24.00 Labs and Diagnostics	0	0	0	0		24.00
25.00 Medical Supplies	0	0	0	0		25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00 Radiation Therapy	0	0	0	0		27.00
28.00 Chemotherapy	0	0	0	0		28.00
29.00 Other	0	0	0	0		29.00
30.00 Bereavement Program Costs	0	0	0	0		30.00
31.00 Volunteer Program Costs	0	0	0	0		31.00
32.00 Fundraising	0	0	0	0		32.00
33.00 Other Program Costs	0	0	0	0		33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	1,711	0	0		34.00
35.00 Total cost to be allocated	0	294	0	0		35.00
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.171829	0.000000	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 151315
 Hospice CCN: 151561

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

Worksheet K-5
 Part III
 Date/Time Prepared:
 2/25/2013 10:02 am

Cost Center Description		Hospice I			
		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)
		0	1.00	2.00	3.00
ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.685865	0	0
2.00	OCCUPATIONAL THERAPY	67.00		0	0
3.00	SPEECH PATHOLOGY	68.00		0	0
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.503640	0	0
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00		0	0
6.00	LABORATORY	60.00	0.367634	0	0
6.01	BLOOD LABORATORY	60.01		0	0
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.513567	0	0
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00		0	0
9.00	RADIOLOGY-THERAPEUTIC	55.00		0	0
10.00	CHEMICAL DEPENDENCY	76.00	2.537353	0	0
10.01	ONCOLOGY	76.01	0.589773	0	0
11.00	Totals (sum of lines 1-10)				

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 151315
 Hospice CCN: 151561

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

Worksheet K-6
 Date/Time Prepared:
 2/25/2013 10:02 am

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				274,448	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				3,715	2.00
3.00	Average cost per diem (line 1 divided by line 2)				73.88	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	3,715				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	274,464				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		0			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		0			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			0		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			0		13.00