

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: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet S Parts I-III Date/Time Prepared: 2/25/2013 10:32 am
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PART I - COST REPORT STATUS

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

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

Date: 2/25/2013 Time: 10:32 am

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 DEKALB MEMORIAL HOSPITAL (150045) 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: 10:32 am
 sARORGeFNXzuj KUuAnDsx6dqL.nzO
 thWtp02l YgWOW.UsHoH6j 4FuR4Li 2k
 Sj Xw1V21Ez0dp1Is
 PI: Date: 2/25/2013 Time: 10:32 am
 ORGqyfvS.oVJ4Di daFzZs8Dcp:ba61
 WUETS01Un.NAuq0ZphQvl kVG7e0:7d
 eJgmFPmFWU0w8Pmz

(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	-36,260	-51,940	87,065	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	0	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	-36,260	-51,940	87,065	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: 150045		Period: From 10/01/2011 To 09/30/2012		Worksheet S-2 Part I Date/Time Prepared: 2/23/2013 9:02 am					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1316 EAST 7TH STREET			PO Box:						1.00	
2.00	City: AUBURN			State: IN		Zip Code: 46706-		County: DEKALB		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00
								V	XVIII	XIX	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		DEKALB MEMORIAL HOSPITAL	150045	99915	1	07/01/1966	N	P	O	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										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		DEKALB HOME HEALTH AGENCY	157157	99915		07/09/1985	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice		DEKALB HOSPICE	151559	99915		11/06/1996				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
17.10	Hospital-Based (CORF) I										17.10
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.						Y	N		22.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3	N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	245	85	15	18	1,171	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: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/23/2013 9:02 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: 150045

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

Worksheet S-2
Part I
Date/Time Prepared:
2/23/2013 9:02 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: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/23/2013 9:02 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				
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N				
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					
		V		XIX		
		1.00		2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	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: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/23/2013 9:02 am	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	243,947	0		118.01
				1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	Y	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
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)		N		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	2.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
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
161.10	CORF		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150045		Period: From 10/01/2011 To 09/30/2012		Worksheet S-2 Part I Date/Time Prepared: 2/23/2013 9:02 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)							168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						1.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part II Date/Time Prepared: 2/23/2013 9:02 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)	N			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	Type	Date	
		1.00	2.00	3.00	
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	Legal Oper.		
		1.00	2.00		
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		Y/N	
		Description	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	01/02/2013		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

		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	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	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	N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	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	01/02/2013	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.	MANGAI NG 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: 150045

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

Worksheet S-3
Part I
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
	Line Number	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	41	15,006	0.00	1.00
2.00 HMO					2.00
3.00 HMO IPF Subprovider					3.00
4.00 HMO IRF Subprovider					4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					5.00
6.00 Hospital Adults & Peds. Swing Bed NF					6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		41	15,006	0.00	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,196	0.00	8.00
9.00 CORONARY CARE UNIT					9.00
10.00 BURN INTENSIVE CARE UNIT					10.00
11.00 SURGICAL INTENSIVE CARE UNIT					11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY	43.00				13.00
14.00 Total (see instructions)		47	17,202	0.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY	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
25.10 CMHC - CORF	99.10				25.10
26.00 RURAL HEALTH CLINIC					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00 Total (sum of lines 14-26)		47			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: 150045

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

Worksheet S-3
Part I
Date/Time Prepared:
2/23/2013 9:02 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	1,543	165	4,149		1.00
2.00 HMO		813	1,203			2.00
3.00 HMO IPF Subprovider		0	0			3.00
4.00 HMO IRF Subprovider		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,543	165	4,149		7.00
8.00 INTENSIVE CARE UNIT	0	397	46	1,141		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		34	864		13.00
14.00 Total (see instructions)	0	1,940	245	6,154		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	2,367	251	5,379		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE		4,413	0	5,275		24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0		25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		187	1,049		28.00
29.00 Ambulance Trips		980				29.00
30.00 Employee discount days (see instruction)				113		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			86	133		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150045

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

Worksheet S-3
Part I
Date/Time Prepared:
2/23/2013 9:02 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	552	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	417.82	0.00	0	552	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	9.44	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00	3.03	0.00			24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	430.29	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: 150045

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

Worksheet S-3
Part I
Date/Time Prepared:
2/23/2013 9:02 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)	261	1,890		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)	261	1,890		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
25.10 CMHC - CORF				25.10
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet S-3 Part II Date/Time Prepared: 2/23/2013 9:02 am			
	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	22,262,761	0	22,262,761	894,996.87	24.87	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		80,580	0	80,580	906.00	88.94	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		5,518,270	63,690	5,581,960	199,777.44	27.94	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		1,336,327	0	1,336,327	25,517.78	52.37	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		171,161	0	171,161	1,670.00	102.49	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Administrative		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		5,725,918	0	5,725,918			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0			18.00
19.00	Excluded areas		1,896,399	0	1,896,399			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		27,539	0	27,539			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits	4.00	189,433	6,347	195,780	5,262.25	37.20	26.00
27.00	Administrative & General	5.00	3,365,105	141,468	3,506,573	152,140.03	23.05	27.00
28.00	Administrative & General under contract (see inst.)		187,569	0	187,569	1,021.71	183.58	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	566,602	9,521	576,123	23,962.60	24.04	30.00
31.00	Laundry & Linen Service	8.00	117,398	2,446	119,844	8,596.12	13.94	31.00
32.00	Housekeeping	9.00	532,403	9,079	541,482	45,831.32	11.81	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	494,197	-324,942	169,255	7,718.13	21.93	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	333,310	333,310	24,695.00	13.50	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	633,175	15,980	649,155	16,672.00	38.94	38.00
39.00	Central Services and Supply	14.00	143,019	2,485	145,504	10,051.47	14.48	39.00
40.00	Pharmacy	15.00	530,862	9,076	539,938	12,878.25	41.93	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150045

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

Worksheet S-3
Part II
Date/Time Prepared:
2/23/2013 9:02 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00 471,527	8,439	479,966	26,322.30	18.23	41.00
42.00	Social Service	17.00 67,449	1,044	68,493	2,181.75	31.39	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150045

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

Worksheet S-3
Part III
Date/Time Prepared:
2/23/2013 9:02 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	22,450,330	0	22,450,330	896,018.58	25.06	1.00
2.00	Excluded area salaries (see instructions)	5,518,270	63,690	5,581,960	199,777.44	27.94	2.00
3.00	Subtotal salaries (line 1 minus line 2)	16,932,060	-63,690	16,868,370	696,241.14	24.23	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,507,488	0	1,507,488	27,187.78	55.45	4.00
5.00	Subtotal wage-related costs (see inst.)	5,753,457	0	5,753,457	0.00	34.11	5.00
6.00	Total (sum of lines 3 thru 5)	24,193,005	-63,690	24,129,315	723,428.92	33.35	6.00
7.00	Total overhead cost (see instructions)	7,298,739	214,253	7,512,992	337,332.93	22.27	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet S-3 Part IV Date/Time Prepared: 2/23/2013 9:02 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			947,252 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			4,596,031 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			0 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			35,088 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			49,444 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			200,947 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			1,727,855 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			31,893 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			61,346 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			7,649,856 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150045

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

Worksheet S-3
Part V
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 150045 Component CCN: 157157		Period: From 10/01/2011 To 09/30/2012		Worksheet S-4 Date/Time Prepared: 2/23/2013 9:02 am		
				Home Health Agency I		PPS		
				1.00				
0.00	County	DEKALB COUNTY					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	336	0	424	760	1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	174.00	0.00	188.00	362.00	2.00	
		Number of Employees (Full Time Equivalent)						
		Enter the number of hours in your normal work week			Staff	Contract	Total	
		0			1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES								
3.00	Administrator and Assistant Administrator(s)	40.00			0.93	0.00	0.93	3.00
4.00	Director(s) and Assistant Director(s)				0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel				2.27	0.00	2.27	5.00
6.00	Direct Nursing Service				4.37	0.00	4.37	6.00
7.00	Nursing Supervisor				2.29	0.00	2.29	7.00
8.00	Physical Therapy Service				1.27	0.00	1.27	8.00
9.00	Physical Therapy Supervisor				0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service				0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor				0.00	0.00	0.00	11.00
12.00	Speech Pathology Service				0.02	0.00	0.02	12.00
13.00	Speech Pathology Supervisor				0.00	0.00	0.00	13.00
14.00	Medical Social Service				0.19	0.00	0.19	14.00
15.00	Medical Social Service Supervisor				0.00	0.00	0.00	15.00
16.00	Home Health Aide				1.38	0.00	1.38	16.00
17.00	Home Health Aide Supervisor				0.00	0.00	0.00	17.00
18.00	Other (specify)				0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES								
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	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	1,363	25	48	18	1,454	21.00	
22.00	Skilled Nursing Visit Charges	237,893	4,375	8,400	3,150	253,818	22.00	
23.00	Physical Therapy Visits	464	0	31	10	505	23.00	
24.00	Physical Therapy Visit Charges	80,056	0	5,331	1,722	87,109	24.00	
25.00	Occupational Therapy Visits	30	0	0	0	30	25.00	
26.00	Occupational Therapy Visit Charges	5,250	0	0	0	5,250	26.00	
27.00	Speech Pathology Visits	18	0	0	0	18	27.00	
28.00	Speech Pathology Visit Charges	3,348	0	0	0	3,348	28.00	
29.00	Medical Social Service Visits	22	0	1	2	25	29.00	
30.00	Medical Social Service Visit Charges	5,813	0	266	532	6,611	30.00	
31.00	Home Health Aide Visits	317	0	3	15	335	31.00	
32.00	Home Health Aide Visit Charges	32,903	0	312	1,560	34,775	32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,214	25	83	45	2,367	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)	365,263	4,375	14,309	6,964	390,911	35.00	
36.00	Total Number of Episodes (standard/non outlier)	162		30	3	195	36.00	
37.00	Total Number of Outlier Episodes		1		0	1	37.00	
38.00	Total Non-Routine Medical Supply Charges	6,850	31	166	0	7,047	38.00	

HOSPITAL IDENTIFICATION DATA

Provider CCN: 150045
Component CCN: 151559

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

Worksheet S-9
Parts I & II
Date/Time Prepared:
2/23/2013 9:02 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	4,410	0	0	0	208	2.00
3.00	Inpatient Respite Care	24	0	0	0	0	3.00
4.00	General Inpatient Care	18	0	0	0	30	4.00
5.00	Total Hospice Days	4,452	0	0	0	238	5.00
Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	84	0	0	0	11	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)	53.00	0.00	0.00	0.00	21.64	8.00
9.00	Unduplicated Census Count	84	0	0	0	11	9.00

HOSPITAL IDENTIFICATION DATA		Provider CCN: 150045 Component CCN: 151559	Period: From 10/01/2011 To 09/30/2012	Worksheet S-9 Parts I & II Date/Time Prepared: 2/23/2013 9:02 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	4,618	2.00
3.00	Inpatient Respite Care	24	3.00
4.00	General Inpatient Care	48	4.00
5.00	Total Hospice Days	4,690	5.00
Part II - CENSUS DATA			
6.00	Number of Patients Receiving Hospice Care	95	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)	49.37	8.00
9.00	Unduplicated Census Count	95	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet S-10 Date/Time Prepared: 2/23/2013 9:02 am
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.387478	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		3,109,785	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		11,183,182	6.00	
7.00	Medicaid cost (line 1 times line 6)		4,333,237	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)		1,223,452	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,223,452	19.00	
			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	874,000	0	874,000	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	338,656	0	338,656	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	338,656	0	338,656	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)		4,525,484	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		59,094	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		4,466,390	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		1,730,628	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,069,284	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,292,736	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150045

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

Worksheet A
Date/Time Prepared:
2/23/2013 9:02 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		4,140,062	4,140,062	-1,917,422	2,222,640	1.00	
1.01 00101 MAC WEST - NEW		0	0	56,247	56,247	1.01	
1.02 00102 NORTH ANNEX - NEW		0	0	5,130	5,130	1.02	
1.03 00103 GARRETT CLINIC - NEW		0	0	4,231	4,231	1.03	
1.04 00104 BUTLER - NEW		0	0	13,860	13,860	1.04	
1.05 00105 MAC EAST - NEW		0	0	172,844	172,844	1.05	
1.06 00106 GARRETT LAB - NEW		0	0	16,689	16,689	1.06	
1.07 00107 MEDICAL ARTS - NEW		0	0	56,866	56,866	1.07	
1.08 00108 DAY SPRING - NEW		0	0	15,683	15,683	1.08	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		0	0	2,096,033	2,096,033	2.00	
3.00 00300 OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00	
4.00 00400 EMPLOYEE BENEFITS	189,433	7,338,994	7,528,427	6,347	7,534,774	4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	3,365,105	5,752,335	9,117,440	-81,163	9,036,277	5.00	
7.00 00700 OPERATION OF PLANT	566,602	1,061,541	1,628,143	43,215	1,671,358	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	117,398	48,546	165,944	2,446	168,390	8.00	
9.00 00900 HOUSEKEEPING	532,403	174,953	707,356	9,260	716,616	9.00	
10.00 01000 DIETARY	472,845	310,579	783,424	-565,857	217,567	10.00	
10.01 01001 SNACK BAR	21,352	29,141	50,493	-42,541	7,952	10.01	
11.00 01100 CAFETERIA	0	0	0	617,252	617,252	11.00	
13.00 01300 NURSING ADMINISTRATION	633,175	17,274	650,449	15,980	666,429	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	143,019	209,866	352,885	2,485	355,370	14.00	
15.00 01500 PHARMACY	530,862	88,033	618,895	9,076	627,971	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	471,527	48,726	520,253	9,116	529,369	16.00	
17.00 01700 SOCIAL SERVICE	67,449	919	68,368	1,044	69,412	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	2,888,016	256,788	3,144,804	-907,451	2,237,353	30.00	
31.00 03100 INTENSIVE CARE UNIT	734,474	113,119	847,593	11,858	859,451	31.00	
43.00 04300 NURSERY	0	3,256	3,256	251,813	255,069	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	1,597,455	1,261,632	2,859,087	42,478	2,901,565	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	245,328	245,328	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,555,887	924,008	2,479,895	-50,405	2,429,490	54.00	
60.00 06000 LABORATORY	1,337,416	1,774,421	3,111,837	74,001	3,185,838	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
65.00 06500 RESPIRATORY THERAPY	0	462,223	462,223	4,060	466,283	65.00	
66.00 06600 PHYSICAL THERAPY	323,216	705,053	1,028,269	-42,242	986,027	66.00	
66.01 06601 CARDIAC REHAB	86,681	12,655	99,336	56,721	156,057	66.01	
69.00 06900 ELECTROCARDIOLOGY	57,161	20,716	77,877	21,774	99,651	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	245,462	245,462	2,570	248,032	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,089,901	1,089,901	-541,361	548,540	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	541,361	541,361	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1,596,118	1,596,118	0	1,596,118	73.00	
OUTPATIENT SERVICE COST CENTERS							
91.00 09100 EMERGENCY	1,053,015	577,868	1,630,883	19,505	1,650,388	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	1,131,275	289,777	1,421,052	29,342	1,450,394	95.00	
99.10 09910 CORF	0	0	0	0	0	99.10	
101.00 10100 HOME HEALTH AGENCY	487,806	122,495	610,301	17,913	628,214	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00 11300 INTEREST EXPENSE		453,184	453,184	-453,184	0	113.00	
116.00 11600 HOSPICE	186,858	184,046	370,904	3,141	374,045	116.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	18,550,430	29,313,691	47,864,121	-125,957	47,738,164	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
191.00 19100 RESEARCH	0	0	0	0	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	120,913	105,522	226,435	71,948	298,383	192.00	
192.01 19201 DEKALB MEDICAL SERVICES	3,574,428	546,177	4,120,605	53,455	4,174,060	192.01	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00	
194.01 07951 ADULT DAY CARE	0	0	0	0	0	194.01	
194.02 07952 FOUNDATION	16,990	2,443	19,433	554	19,987	194.02	
200.00	TOTAL (SUM OF LINES 118-199)	22,262,761	29,967,833	52,230,594	0	52,230,594	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150045

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

Worksheet A
Date/Time Prepared:
2/23/2013 9:02 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	-455,184	1,767,456	1.00
1.01	00101	MAC WEST - NEW	0	56,247	1.01
1.02	00102	NORTH ANNEX - NEW	0	5,130	1.02
1.03	00103	GARRETT CLINIC - NEW	0	4,231	1.03
1.04	00104	BUTLER - NEW	0	13,860	1.04
1.05	00105	MAC EAST - NEW	0	172,844	1.05
1.06	00106	GARRETT LAB - NEW	0	16,689	1.06
1.07	00107	MEDICAL ARTS - NEW	0	56,866	1.07
1.08	00108	DAY SPRING - NEW	0	15,683	1.08
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-8,844	2,087,189	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	-630,285	6,904,489	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-805,437	8,230,840	5.00
7.00	00700	OPERATION OF PLANT	-27,356	1,644,002	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-2,004	166,386	8.00
9.00	00900	HOUSEKEEPING	-8,137	708,479	9.00
10.00	01000	DIETARY	0	217,567	10.00
10.01	01001	SNACK BAR	-7,952	0	10.01
11.00	01100	CAFETERIA	-237,896	379,356	11.00
13.00	01300	NURSING ADMINISTRATION	0	666,429	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-5	355,365	14.00
15.00	01500	PHARMACY	-169,244	458,727	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,316	527,053	16.00
17.00	01700	SOCIAL SERVICE	0	69,412	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-835	2,236,518	30.00
31.00	03100	INTENSIVE CARE UNIT	-58,103	801,348	31.00
43.00	04300	NURSERY	0	255,069	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-931,479	1,970,086	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	245,328	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-107,380	2,322,110	54.00
60.00	06000	LABORATORY	-55,036	3,130,802	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	466,283	65.00
66.00	06600	PHYSICAL THERAPY	-4,909	981,118	66.00
66.01	06601	CARDIAC REHAB	-17,904	138,153	66.01
69.00	06900	ELECTROCARDIOLOGY	0	99,651	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	248,032	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	548,540	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	541,361	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-7,545	1,588,573	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-477,951	1,172,437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-428,352	1,022,042	95.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	-27,543	600,671	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	-96	373,949	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,471,793	43,266,371	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	298,383	192.00
192.01	19201	DEKALB MEDICAL SERVICES	-265	4,173,795	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	194.01
194.02	07952	FOUNDATION	0	19,987	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-4,472,058	47,758,536	200.00

RECLASSIFICATIONS

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Period:
From 10/01/2011
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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - LABOR AND DELIVERY					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	220,428	24,900	1.00
	TOTALS		220,428	24,900	
B - NURSERY RECLASS					
1.00	NURSERY	43.00	226,255	25,558	1.00
	TOTALS		226,255	25,558	
C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	333,310	283,942	1.00
2.00		0.00	0	0	2.00
	TOTALS		333,310	283,942	
D - INTEREST RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	453,184	1.00
	TOTALS		0	453,184	
E - DEPRECIATION RECLASS					
1.00	MAC WEST - NEW	1.01	0	56,247	1.00
2.00	NORTH ANNEX - NEW	1.02	0	5,130	2.00
3.00	GARRETT CLINIC - NEW	1.03	0	4,231	3.00
4.00	BUTLER - NEW	1.04	0	13,860	4.00
5.00	MAC EAST - NEW	1.05	0	172,844	5.00
6.00	GARRETT LAB - NEW	1.06	0	16,689	6.00
7.00	MEDICAL ARTS - NEW	1.07	0	56,866	7.00
8.00	DAY SPRING - NEW	1.08	0	15,683	8.00
9.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2,096,033	9.00
	TOTALS		0	2,437,583	
F - ANCILLARY SERVICE RECLASS					
1.00	LABORATORY	60.00	40,842	86	1.00
2.00	RESPIRATORY THERAPY	65.00	4,051	9	2.00
3.00	PHYSICAL THERAPY	66.00	5,902	12	3.00
4.00	CARDIAC REHAB	66.01	733	2	4.00
5.00	ELECTROCARDIOLOGY	69.00	1,759	4	5.00
6.00	ELECTROENCEPHALOGRAPHY	70.00	2,565	5	6.00
7.00	AMBULANCE SERVICES	95.00	9,098	19	7.00
	TOTALS		64,950	137	
G - NORTH ANNEX RECLASS					
1.00	HOME HEALTH AGENCY	101.00	0	7,556	1.00
2.00	HOSPICE	116.00	0	818	2.00
	TOTALS		0	8,374	
H - MOB WEST RECLASS					
1.00	OPERATION OF PLANT	7.00	0	5,807	1.00
2.00	LABORATORY	60.00	0	1,316	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	25,241	3.00
	TOTALS		0	32,364	
I - MOB EAST RECLASS					
1.00	OPERATION OF PLANT	7.00	0	26,555	1.00
2.00	HOUSEKEEPING	9.00	0	181	2.00
3.00	DIETARY	10.00	0	486	3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	677	4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	30,863	5.00
6.00	DEKALB MEDICAL SERVICES	192.01	0	18,620	6.00
	TOTALS		0	77,382	
J - REHABILITATION OFFICE RECLASS					
1.00	CARDIAC REHAB	66.01	45,628	8,808	1.00
	TOTALS		45,628	8,808	
K - BUTLER CLINIC RECLASS					
1.00	LABORATORY	60.00	0	2,319	1.00
	TOTALS		0	2,319	
L - GARRETT MOB RECLASS					
1.00	LABORATORY	60.00	0	4,337	1.00
2.00	DEKALB MEDICAL SERVICES	192.01	0	16,406	2.00
	TOTALS		0	20,743	
M - MEDICAL ARTS BUILDING RECLASS					
1.00	OPERATION OF PLANT	7.00	0	1,332	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	12,816	2.00
3.00	DEKALB MEDICAL SERVICES	192.01	0	2,643	3.00
	TOTALS		0	16,791	
N - ANCILLARY - EKG SUPPORT RECLASS					
1.00	ELECTROCARDIOLOGY	69.00	12,318	7,146	1.00
	TOTALS		12,318	7,146	
O - IMPLANTABLE DEVICES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	541,361	1.00
	TOTALS		0	541,361	

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Period:
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Worksheet A-6

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		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
P - BONUS ACCRUAL RECLASS						
1.00	EMPLOYEE BENEFITS	4.00	6,347	0	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	141,468	0	2.00	
3.00	OPERATION OF PLANT	7.00	9,521	0	3.00	
4.00	LAUNDRY & LINEN SERVICE	8.00	2,446	0	4.00	
5.00	HOUSEKEEPING	9.00	9,079	0	5.00	
6.00	DIETARY	10.00	7,980	0	6.00	
7.00	SNACK BAR	10.01	388	0	7.00	
8.00	NURSING ADMINISTRATION	13.00	15,980	0	8.00	
9.00	CENTRAL SERVICES & SUPPLY	14.00	2,485	0	9.00	
10.00	PHARMACY	15.00	9,076	0	10.00	
11.00	MEDICAL RECORDS & LIBRARY	16.00	8,439	0	11.00	
12.00	SOCIAL SERVICE	17.00	1,044	0	12.00	
13.00	INTENSIVE CARE UNIT	31.00	11,858	0	13.00	
14.00	OPERATING ROOM	50.00	42,478	0	14.00	
15.00	RADIOLOGY-DIAGNOSTIC	54.00	34,146	0	15.00	
16.00	LABORATORY	60.00	25,101	0	16.00	
17.00	PHYSICAL THERAPY	66.00	6,280	0	17.00	
18.00	CARDIAC REHAB	66.01	1,550	0	18.00	
19.00	ELECTROCARDIOLOGY	69.00	547	0	19.00	
20.00	EMERGENCY	91.00	19,505	0	20.00	
21.00	AMBULANCE SERVICES	95.00	20,225	0	21.00	
22.00	HOME HEALTH AGENCY	101.00	10,357	0	22.00	
23.00	HOSPICE	116.00	2,323	0	23.00	
24.00	PHYSICIANS' PRIVATE OFFICES	192.00	3,028	0	24.00	
25.00	DEKALB MEDICAL SERVICES	192.01	18,105	0	25.00	
26.00	FOUNDATION	194.02	554	0	26.00	
TOTALS			410,310	0		
Q - PROPERTY INSURANCE RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	66,977	1.00	
TOTALS			0	66,977		
500.00	Grand Total: Increases		1,313,199	4,007,569	500.00	

RECLASSIFICATIONS

Provider CCN: 150045

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

Worksheet A-6
Date/Time Prepared:
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		Decreases				Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - LABOR AND DELIVERY							
1.00	ADULTS & PEDIATRICS	30.00	220,428	24,900	0		1.00
	TOTALS		220,428	24,900			
B - NURSERY RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	226,255	25,558	0		1.00
	TOTALS		226,255	25,558			
C - CAFETERIA RECLASS							
1.00	DIETARY	10.00	315,157	259,166	0		1.00
2.00	SNACK BAR	10.01	18,153	24,776	0		2.00
	TOTALS		333,310	283,942			
D - INTEREST RECLASS							
1.00	INTEREST EXPENSE	113.00	0	453,184	11		1.00
	TOTALS		0	453,184			
E - DEPRECIATION RECLASS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,437,583	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
4.00		0.00	0	0	9		4.00
5.00		0.00	0	0	9		5.00
6.00		0.00	0	0	9		6.00
7.00		0.00	0	0	9		7.00
8.00		0.00	0	0	9		8.00
9.00		0.00	0	0	9		9.00
	TOTALS		0	2,437,583			
F - ANCILLARY SERVICE RECLASS							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	64,950	137	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	TOTALS		64,950	137			
G - NORTH ANNEX RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,374	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	8,374			
H - MOB WEST RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	32,364	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	32,364			
I - MOB EAST RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	77,382	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		0	77,382			
J - REHABILITATION OFFICE RECLASS							
1.00	PHYSICAL THERAPY	66.00	45,628	8,808	0		1.00
	TOTALS		45,628	8,808			
K - BUTLER CLINIC RECLASS							
1.00	DEKALB MEDICAL SERVICES	192.01	0	2,319	0		1.00
	TOTALS		0	2,319			
L - GARRETT MOB RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,743	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	20,743			
M - MEDICAL ARTS BUILDING RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,791	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	16,791			
N - ANCILLARY - EKG SUPPORT RECLASS							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	12,318	7,146	0		1.00
	TOTALS		12,318	7,146			
O - IMPLANTABLE DEVICES RECLASS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	541,361	0		1.00
	TOTALS		0	541,361			

Provider CCN: 150045

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

Worksheet A-6

Date/Time Prepared:
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		Decreases						
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.			
6.00		7.00	8.00	9.00	10.00			
P - BONUS ACCRUAL RECLASS								
1.00	ADULTS & PEDIATRICS	30.00	410,310	0	0	0	1.00	
2.00		0.00	0	0	0	0	2.00	
3.00		0.00	0	0	0	0	3.00	
4.00		0.00	0	0	0	0	4.00	
5.00		0.00	0	0	0	0	5.00	
6.00		0.00	0	0	0	0	6.00	
7.00		0.00	0	0	0	0	7.00	
8.00		0.00	0	0	0	0	8.00	
9.00		0.00	0	0	0	0	9.00	
10.00		0.00	0	0	0	0	10.00	
11.00		0.00	0	0	0	0	11.00	
12.00		0.00	0	0	0	0	12.00	
13.00		0.00	0	0	0	0	13.00	
14.00		0.00	0	0	0	0	14.00	
15.00		0.00	0	0	0	0	15.00	
16.00		0.00	0	0	0	0	16.00	
17.00		0.00	0	0	0	0	17.00	
18.00		0.00	0	0	0	0	18.00	
19.00		0.00	0	0	0	0	19.00	
20.00		0.00	0	0	0	0	20.00	
21.00		0.00	0	0	0	0	21.00	
22.00		0.00	0	0	0	0	22.00	
23.00		0.00	0	0	0	0	23.00	
24.00		0.00	0	0	0	0	24.00	
25.00		0.00	0	0	0	0	25.00	
26.00		0.00	0	0	0	0	26.00	
TOTALS			410,310	0				
Q - PROPERTY INSURANCE RECLASS								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	66,977	12		1.00	
TOTALS			0	66,977				
500.00	Grand Total: Decreases		1,313,199	4,007,569			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150045

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
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		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	220,118	173,000	0	173,000	0	1.00
2.00	Land Improvements	1,696,200	258,899	0	258,899	0	2.00
3.00	Buildings and Fixtures	44,979,173	8,803,478	0	8,803,478	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	26,017,062	12,434,167	0	12,434,167	16,318,308	6.00
7.00	HIT designated Assets	0	1,369,610	0	1,369,610	0	7.00
8.00	Subtotal (sum of lines 1-7)	72,912,553	23,039,154	0	23,039,154	16,318,308	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	72,912,553	23,039,154	0	23,039,154	16,318,308	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	4,140,062	0	0	0	0	1.00
1.01	MAC WEST - NEW	0	0	0	0	0	1.01
1.02	NORTH ANNEX - NEW	0	0	0	0	0	1.02
1.03	GARRETT CLINIC - NEW	0	0	0	0	0	1.03
1.04	BUTLER - NEW	0	0	0	0	0	1.04
1.05	MAC EAST - NEW	0	0	0	0	0	1.05
1.06	GARRETT LAB - NEW	0	0	0	0	0	1.06
1.07	MEDICAL ARTS - NEW	0	0	0	0	0	1.07
1.08	DAY SPRING - NEW	0	0	0	0	0	1.08
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,140,062	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	56,130,868	0	56,130,868	0.704866	0	1.00
1.01	MAC WEST - NEW	0	0	0	0.000000	0	1.01
1.02	NORTH ANNEX - NEW	0	0	0	0.000000	0	1.02
1.03	GARRETT CLINIC - NEW	0	0	0	0.000000	0	1.03
1.04	BUTLER - NEW	0	0	0	0.000000	0	1.04
1.05	MAC EAST - NEW	0	0	0	0.000000	0	1.05
1.06	GARRETT LAB - NEW	0	0	0	0.000000	0	1.06
1.07	MEDICAL ARTS - NEW	0	0	0	0.000000	0	1.07
1.08	DAY SPRING - NEW	0	0	0	0.000000	0	1.08
2.00	NEW CAP REL COSTS-MVBLE EQUIP	23,502,531	0	23,502,531	0.295134	0	2.00
3.00	Total (sum of lines 1-2)	79,633,399	0	79,633,399	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150045

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
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		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	393,118	0			1.00	
2.00	Land Improvements	1,955,099	0			2.00	
3.00	Buildings and Fixtures	53,782,651	0			3.00	
4.00	Building Improvements	0	0			4.00	
5.00	Fixed Equipment	0	0			5.00	
6.00	Movable Equipment	22,132,921	0			6.00	
7.00	HIT designated Assets	1,369,610	0			7.00	
8.00	Subtotal (sum of lines 1-7)	79,633,399	0			8.00	
9.00	Reconciling Items	0	0			9.00	
10.00	Total (line 8 minus line 9)	79,633,399	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	4,140,062			1.00	
1.01	MAC WEST - NEW	0	0			1.01	
1.02	NORTH ANNEX - NEW	0	0			1.02	
1.03	GARRETT CLINIC - NEW	0	0			1.03	
1.04	BUTLER - NEW	0	0			1.04	
1.05	MAC EAST - NEW	0	0			1.05	
1.06	GARRETT LAB - NEW	0	0			1.06	
1.07	MEDICAL ARTS - NEW	0	0			1.07	
1.08	DAY SPRING - NEW	0	0			1.08	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0			2.00	
3.00	Total (sum of lines 1-2)	0	4,140,062			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	1,700,479	-453,184	1.00
1.01	MAC WEST - NEW	0	0	0	56,247	0	1.01
1.02	NORTH ANNEX - NEW	0	0	0	5,130	0	1.02
1.03	GARRETT CLINIC - NEW	0	0	0	4,231	0	1.03
1.04	BUTLER - NEW	0	0	0	13,860	0	1.04
1.05	MAC EAST - NEW	0	0	0	172,844	0	1.05
1.06	GARRETT LAB - NEW	0	0	0	16,689	0	1.06
1.07	MEDICAL ARTS - NEW	0	0	0	56,866	0	1.07
1.08	DAY SPRING - NEW	0	0	0	15,683	0	1.08
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,087,189	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,129,218	-453,184	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150045

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
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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	453,184	66,977	0	0	1,767,456	1.00
1.01	MAC WEST - NEW	0	0	0	0	56,247	1.01
1.02	NORTH ANNEX - NEW	0	0	0	0	5,130	1.02
1.03	GARRETT CLINIC - NEW	0	0	0	0	4,231	1.03
1.04	BUTLER - NEW	0	0	0	0	13,860	1.04
1.05	MAC EAST - NEW	0	0	0	0	172,844	1.05
1.06	GARRETT LAB - NEW	0	0	0	0	16,689	1.06
1.07	MEDICAL ARTS - NEW	0	0	0	0	56,866	1.07
1.08	DAY SPRING - NEW	0	0	0	0	15,683	1.08
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,087,189	2.00
3.00	Total (sum of lines 1-2)	453,184	66,977	0	0	4,196,195	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150045

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

Worksheet A-8

Date/Time Prepared:
2/23/2013 9:02 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	-453,184	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
1.01 Investment income - MAC WEST - NEW (chapter 2)			OMAC WEST - NEW	1.01	1.01
1.02 Investment income - NORTH ANNEX - NEW (chapter 2)			ONORTH ANNEX - NEW	1.02	1.02
1.03 Investment income - GARRETT CLINIC - NEW (chapter 2)			OGARRETT CLINIC - NEW	1.03	1.03
1.04 Investment income - BUTLER - NEW (chapter 2)			OBUTLER - NEW	1.04	1.04
1.05 Investment income - MAC EAST - NEW (chapter 2)			OMAC EAST - NEW	1.05	1.05
1.06 Investment income - GARRETT LAB - NEW (chapter 2)			OGARRETT LAB - NEW	1.06	1.06
1.07 Investment income - MEDICAL ARTS - NEW (chapter 2)			OMEDICAL ARTS - NEW	1.07	1.07
1.08 Investment income - DAY SPRING - NEW (chapter 2)			ODAY SPRING - NEW	1.08	1.08
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW 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)		0		0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00 Television and radio service (chapter 21)		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	-659,155			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	0			12.00
13.00 Laundry and linen service	B	-2,004	LAUNDRY & LINEN SERVICE	8.00	13.00
14.00 Cafeteria-employees and guests	B	-230,254	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	-169,244	PHARMACY	15.00	17.00
18.00 Sale of medical records and abstracts	B	-2,316	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	-7,642	CAFETERIA	11.00	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)			0*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
26.01 Depreciation - MAC WEST - NEW			OMAC WEST - NEW	1.01	26.01
26.02 Depreciation - NORTH ANNEX - NEW			ONORTH ANNEX - NEW	1.02	26.02
26.03 Depreciation - GARRETT CLINIC - NEW			OGARRETT CLINIC - NEW	1.03	26.03
26.04 Depreciation - BUTLER - NEW			OBUTLER - NEW	1.04	26.04
26.05 Depreciation - MAC EAST - NEW			OMAC EAST - NEW	1.05	26.05
26.06 Depreciation - GARRETT LAB - NEW			OGARRETT LAB - NEW	1.06	26.06
26.07 Depreciation - MEDICAL ARTS - NEW			OMEDICAL ARTS - NEW	1.07	26.07
26.08 Depreciation - DAY SPRING - NEW			ODAY SPRING - NEW	1.08	26.08
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW 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

ADJUSTMENTS TO EXPENSES

Provider CCN: 150045

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

Worksheet A-8

Date/Time Prepared:
2/23/2013 9:02 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
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		0			0.00 32.00	
33.00 MISCELLANEOUS INCOME	B	-14	EMPLOYEE BENEFITS		4.00 33.00	
33.01 MISCELLANEOUS INCOME	B	-131,745	ADMINISTRATIVE & GENERAL		5.00 33.01	
33.02 CREDENTIALLY SERVICES INCOME	B	-13,250	ADMINISTRATIVE & GENERAL		5.00 33.02	
33.03 COMMUNITY SERVICES INCOME	B	-25	ADMINISTRATIVE & GENERAL		5.00 33.03	
33.04 CENTRAL SUPPLY NON-PATIENT REVENUE	B	-5	CENTRAL SERVICES & SUPPLY		14.00 33.04	
33.05 WASTE DISPOSAL REVENUE	B	-704	OPERATION OF PLANT		7.00 33.05	
33.06 MISCELLANEOUS INCOME	B	-26,652	OPERATION OF PLANT		7.00 33.06	
33.07 HOUSEKEEPING INCOME	B	-8,137	HOUSEKEEPING		9.00 33.07	
33.08 OBSTETRICS MISCELLANEOUS INCOME	B	-835	ADULTS & PEDIATRICS		30.00 33.08	
33.09 RADIOLOGY NON-PATIENT REVENUE	B	-7,772	RADIOLOGY-DIAGNOSTIC		54.00 33.09	
33.10 NON-PATIENT LAB REVENUE	B	-41,811	LABORATORY		60.00 33.10	
33.11 MISCELLANEOUS INCOME	B	-15,649	CARDIAC REHAB		66.01 33.11	
33.12 MISCELLANEOUS INCOME	B	-7,545	DRUGS CHARGED TO PATIENTS		73.00 33.12	
33.13 AMBULANCE SERVICE REVENUE	B	-54,357	AMBULANCE SERVICES		95.00 33.13	
33.14 AMBULANCE SUBSIDY	B	-372,846	AMBULANCE SERVICES		95.00 33.14	
33.15 MISCELLANEOUS INCOME	B	-525	LABORATORY		60.00 33.15	
33.16 LOBBYING PORTION OF IHA & AHA DUES	A	-6,259	ADMINISTRATIVE & GENERAL		5.00 33.16	
33.17 LOBBYING PORTION OF IAHC DUES - HOS	A	-71	HOSPICE		116.00 33.17	
33.18 LOBBYING PORTION OF IAHC DUES - HHA	A	-106	HOME HEALTH AGENCY		101.00 33.18	
33.19 NON-ALLOWABLE MARKETING	A	-529,835	ADMINISTRATIVE & GENERAL		5.00 33.19	
33.20 NON-ALLOWABLE MARKETING	A	-3,445	RADIOLOGY-DIAGNOSTIC		54.00 33.20	
33.21 NON-ALLOWABLE MARKETING	A	-4,909	PHYSICAL THERAPY		66.00 33.21	
33.22 NON-ALLOWABLE MARKETING	A	-1,266	CARDIAC REHAB		66.01 33.22	
33.23 NON-ALLOWABLE MARKETING	A	-2,105	HOME HEALTH AGENCY		101.00 33.23	
33.24 NON-ALLOWABLE MARKETING	A	-25	HOSPICE		116.00 33.24	
33.25 NON-ALLOWABLE MARKETING	A	-265	DEKALB MEDICAL SERVICES		192.01 33.25	
33.26 LI FELINE EXPENSES	A	-25,332	HOME HEALTH AGENCY		101.00 33.26	
33.27 LI FELINE EXPENSES - DEPRECIATION	A	-8,844	NEW CAP REL COSTS-MVBLE EQUIP		2.00 33.27	
33.28 SNACK BAR	A	-7,952	SNACK BAR		10.01 33.28	
33.29 PHYSICIAN GUARANTEE	A	-919,379	OPERATING ROOM		50.00 33.29	
33.30 GOLF OUTING	A	-13,121	ADMINISTRATIVE & GENERAL		5.00 33.30	
33.31 FLOWER/GIFTS	A	-8,129	ADMINISTRATIVE & GENERAL		5.00 33.31	
33.32 SELF-INSURANCE EXPENSES	A	-630,201	EMPLOYEE BENEFITS		4.00 33.32	
33.33 CHRISTMAS PARTY & OPEN HOUSE	A	-32,482	ADMINISTRATIVE & GENERAL		5.00 33.33	
33.34 SPORTING EVENT TICKETS	A	-70	EMPLOYEE BENEFITS		4.00 33.34	
33.35 PHYSICIAN RECRUITMENT	A	-70,591	ADMINISTRATIVE & GENERAL		5.00 33.35	
33.36 DAY SPRING RENTAL INCOME OFFSET	A	-2,000	NEW CAP REL COSTS-BLDG & FIXT		1.00 33.36	
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,472,058			50.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 150045

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

Worksheet A-8

Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	10	1.00
1.01	Investment income - MAC WEST - NEW (chapter 2)	0	1.01
1.02	Investment income - NORTH ANNEX - NEW (chapter 2)	0	1.02
1.03	Investment income - GARRETT CLINIC - NEW (chapter 2)	0	1.03
1.04	Investment income - BUTLER - NEW (chapter 2)	0	1.04
1.05	Investment income - MAC EAST - NEW (chapter 2)	0	1.05
1.06	Investment income - GARRETT LAB - NEW (chapter 2)	0	1.06
1.07	Investment income - MEDICAL ARTS - NEW (chapter 2)	0	1.07
1.08	Investment income - DAY SPRING - NEW (chapter 2)	0	1.08
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
26.01	Depreciation - MAC WEST - NEW	0	26.01
26.02	Depreciation - NORTH ANNEX - NEW	0	26.02
26.03	Depreciation - GARRETT CLINIC - NEW	0	26.03
26.04	Depreciation - BUTLER - NEW	0	26.04
26.05	Depreciation - MAC EAST - NEW	0	26.05
26.06	Depreciation - GARRETT LAB - NEW	0	26.06
26.07	Depreciation - MEDICAL ARTS - NEW	0	26.07
26.08	Depreciation - DAY SPRING - NEW	0	26.08
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	0	32.00
33.00	MISCELLANEOUS INCOME	0	33.00
33.01	MISCELLANEOUS INCOME	0	33.01
33.02	CREDENTIALLY SERVICES INCOME	0	33.02
33.03	COMMUNITY SERVICES INCOME	0	33.03
33.04	CENTRAL SUPPLY NON-PATIENT REVENUE	0	33.04

ADJUSTMENTS TO EXPENSES

Provider CCN: 150045

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

Worksheet A-8

Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
33.05	WASTE DISPOSAL REVENUE	0	33.05
33.06	MISCELLANEOUS INCOME	0	33.06
33.07	HOUSEKEEPING INCOME	0	33.07
33.08	OBSTETRICS MISCELLANEOUS INCOME	0	33.08
33.09	RADIOLOGY NON-PATIENT REVENUE	0	33.09
33.10	NON-PATIENT LAB REVENUE	0	33.10
33.11	MISCELLANEOUS INCOME	0	33.11
33.12	MISCELLANEOUS INCOME	0	33.12
33.13	AMBULANCE SERVICE REVENUE	0	33.13
33.14	AMBULANCE SUBSIDY	0	33.14
33.15	MISCELLANEOUS INCOME	0	33.15
33.16	LOBBYING PORTION OF IHA & AHA DUES	0	33.16
33.17	LOBBYING PORTION OF IAHC DUES - HOS	0	33.17
33.18	LOBBYING PORTION OF IAHC DUES - HHA	0	33.18
33.19	NON-ALLOWABLE MARKETING	0	33.19
33.20	NON-ALLOWABLE MARKETING	0	33.20
33.21	NON-ALLOWABLE MARKETING	0	33.21
33.22	NON-ALLOWABLE MARKETING	0	33.22
33.23	NON-ALLOWABLE MARKETING	0	33.23
33.24	NON-ALLOWABLE MARKETING	0	33.24
33.25	NON-ALLOWABLE MARKETING	0	33.25
33.26	LIFELINE EXPENSES	0	33.26
33.27	LIFELINE EXPENSES - DEPRECIATION	9	33.27
33.28	SNACK BAR	0	33.28
33.29	PHYSICIAN GUARANTEE	0	33.29
33.30	GOLF OUTING	0	33.30
33.31	FLOWER/GIFTS	0	33.31
33.32	SELF-INSURANCE EXPENSES	0	33.32
33.33	CHRISTMAS PARTY & OPEN HOUSE	0	33.33
33.34	SPORTING EVENT TICKETS	0	33.34
33.35	PHYSICIAN RECRUITMENT	0	33.35
33.36	DAY SPRING RENTAL INCOME OFFSET	9	33.36
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150045

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

Worksheet A-8-2

Date/Time Prepared:
2/23/2013 9:02 am

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		31.00	INTENSIVE CARE UNIT	58,103	58,103	1.00
2.00		50.00	OPERATING ROOM	12,100	12,100	2.00
3.00		54.00	RADIOLOGY-DIAGNOSTIC	98,674	95,362	3.00
4.00		60.00	LABORATORY	75,000	0	4.00
5.00		66.01	CARDIAC REHAB	3,250	0	5.00
6.00		91.00	EMERGENCY	488,503	476,503	6.00
7.00		95.00	AMBULANCE SERVICES	8,000	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				743,630	642,068	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150045

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

Worksheet A-8-2

Date/Time Prepared:
2/23/2013 9:02 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	0	182,900	0	0	0	1.00
2.00	0	182,900	0	0	0	2.00
3.00	3,312	217,600	24	2,511	126	3.00
4.00	75,000	208,000	623	62,300	3,115	4.00
5.00	3,250	142,500	33	2,261	113	5.00
6.00	12,000	182,900	120	10,552	528	6.00
7.00	8,000	142,500	100	6,851	343	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	101,562		900	84,475	4,225	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150045

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

Worksheet A-8-2

Date/Time Prepared:
2/23/2013 9:02 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	2,511	3.00
4.00	0	0	0	0	62,300	4.00
5.00	0	0	0	0	2,261	5.00
6.00	0	0	0	0	10,552	6.00
7.00	0	0	0	0	6,851	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	84,475	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150045

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

Worksheet A-8-2
Date/Time Prepared:
2/23/2013 9:02 am

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	58,103	1.00
2.00	0	12,100	2.00
3.00	801	96,163	3.00
4.00	12,700	12,700	4.00
5.00	989	989	5.00
6.00	1,448	477,951	6.00
7.00	1,149	1,149	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	17,087	659,155	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150045

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

Worksheet B
Part I
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				GARRETT CLINIC - NEW	
		NEW BLDG & FIXT	MAC WEST - NEW	NORTH ANNEX - NEW			
		1.00	1.01	1.02	1.03		
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	1,767,456	1,767,456					1.00
1.01 00101 MAC WEST - NEW	56,247	0	56,247				1.01
1.02 00102 NORTH ANNEX - NEW	5,130	0	0	5,130			1.02
1.03 00103 GARRETT CLINIC - NEW	4,231	0	0	0	4,231		1.03
1.04 00104 BUTLER - NEW	13,860	0	0	0	0		1.04
1.05 00105 MAC EAST - NEW	172,844	0	0	0	0		1.05
1.06 00106 GARRETT LAB - NEW	16,689	0	0	0	0		1.06
1.07 00107 MEDICAL ARTS - NEW	56,866	0	0	0	0		1.07
1.08 00108 DAY SPRING - NEW	15,683	0	0	0	0		1.08
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	2,087,189						2.00
4.00 00400 EMPLOYEE BENEFITS	6,904,489	0	0	0	0		4.00
5.00 00500 ADMINISTRATIVE & GENERAL	8,230,840	92,167	0	2,099	0		5.00
7.00 00700 OPERATION OF PLANT	1,644,002	783,929	10,093	0	0		7.00
8.00 00800 LAUNDRY & LINEN SERVICE	166,386	11,674	0	0	0		8.00
9.00 00900 HOUSEKEEPING	708,479	18,566	0	0	0		9.00
10.00 01000 DIETARY	217,567	9,796	0	0	0		10.00
10.01 01001 SNACK BAR	0	0	0	0	0		10.01
11.00 01100 CAFETERIA	379,356	23,044	0	0	0		11.00
13.00 01300 NURSING ADMINISTRATION	666,429	10,364	0	0	0		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	355,365	12,309	0	0	0		14.00
15.00 01500 PHARMACY	458,727	11,322	0	0	0		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	527,053	27,326	0	0	0		16.00
17.00 01700 SOCIAL SERVICE	69,412	1,603	0	0	0		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	2,236,518	173,452	0	0	0		30.00
31.00 03100 INTENSIVE CARE UNIT	801,348	46,147	0	0	0		31.00
43.00 04300 NURSERY	255,069	15,799	0	0	0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	1,970,086	114,644	0	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	245,328	48,181	0	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,322,110	88,569	0	0	0		54.00
60.00 06000 LABORATORY	3,130,802	40,740	2,287	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	466,283	10,921	0	0	0		65.00
66.00 06600 PHYSICAL THERAPY	981,118	50,996	0	0	0		66.00
66.01 06601 CARDIAC REHAB	138,153	26,838	0	0	0		66.01
69.00 06900 ELECTROCARDIOLOGY	99,651	313	0	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	248,032	0	0	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	548,540	0	0	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	541,361	0	0	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,588,573	0	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS							
91.00 09100 EMERGENCY	1,172,437	72,310	0	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)							92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	1,022,042	26,574	0	0	0		95.00
99.10 09910 CORF	0	0	0	0	0		99.10
101.00 10100 HOME HEALTH AGENCY	600,671	0	0	2,735	0		101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300 INTEREST EXPENSE							113.00
116.00 11600 HOSPICE	373,949	0	0	296	0		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	43,266,371	1,717,584	12,380	5,130		118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0		190.00
191.00 19100 RESEARCH	0	0	0	0	0		191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	298,383	49,872	40,055	0	4,231		192.00
192.01 19201 DEKALB MEDICAL SERVICES	4,173,795	0	3,812	0	0		192.01
193.00 19300 NONPAID WORKERS	0	0	0	0	0		193.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0		194.00
194.01 07951 ADULT DAY CARE	0	0	0	0	0		194.01
194.02 07952 FOUNDATION	19,987	0	0	0	0		194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	TOTAL (sum lines 118-201)	47,758,536	1,767,456	56,247	5,130	4,231	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150045

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

Worksheet B
Part I
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Cost Center Description	CAPITAL RELATED COSTS					DAY SPRING - NEW	
	BUTLER - NEW	MAC EAST - NEW	GARRETT LAB - NEW	MEDICAL ARTS - NEW			
	1.04	1.05	1.06	1.07	1.08		
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101	MAC WEST - NEW						1.01
1.02 00102	NORTH ANNEX - NEW						1.02
1.03 00103	GARRETT CLINIC - NEW						1.03
1.04 00104	BUTLER - NEW	13,860					1.04
1.05 00105	MAC EAST - NEW	0	172,844				1.05
1.06 00106	GARRETT LAB - NEW	0	0	16,689			1.06
1.07 00107	MEDICAL ARTS - NEW	0	0	0	56,866		1.07
1.08 00108	DAY SPRING - NEW	0	0	0	0	15,683	1.08
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	23,145	0	0	15,683	5.00
7.00 00700	OPERATION OF PLANT	0	51,372	0	4,509	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	350	0	0	0	9.00
10.00 01000	DIETARY	0	941	0	0	0	10.00
10.01 01001	SNACK BAR	0	0	0	0	0	10.01
11.00 01100	CAFETERIA	0	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	1,310	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	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
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 06000	LABORATORY	980	0	3,489	0	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01 06601	CARDIAC REHAB	0	0	0	0	0	66.01
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
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
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10 09910	CORF	0	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
116.00 11600	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	980	77,118	3,489	4,509	15,683	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	59,705	0	43,404	0	192.00
192.01 19201	DEKALB MEDICAL SERVICES	12,880	36,021	13,200	8,953	0	192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02 07952	FOUNDATION	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	13,860	172,844	16,689	56,866	15,683	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150045

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
	NEW MVBLE EQUIP						
	2.00	4.00					
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101	MAC WEST - NEW						1.01
1.02 00102	NORTH ANNEX - NEW						1.02
1.03 00103	GARRETT CLINIC - NEW						1.03
1.04 00104	BUTLER - NEW						1.04
1.05 00105	MAC EAST - NEW						1.05
1.06 00106	GARRETT LAB - NEW						1.06
1.07 00107	MEDICAL ARTS - NEW						1.07
1.08 00108	DAY SPRING - NEW						1.08
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	2,087,189					2.00
4.00 00400	EMPLOYEE BENEFITS	0	6,904,489				4.00
5.00 00500	ADMINISTRATIVE & GENERAL	108,840	1,097,343	9,570,117	9,570,117		5.00
7.00 00700	OPERATION OF PLANT	925,744	180,291	3,599,940	902,156	4,502,096	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	13,785	37,504	229,349	57,476	35,263	8.00
9.00 00900	HOUSEKEEPING	21,925	169,451	918,771	230,247	58,329	9.00
10.00 01000	DIETARY	11,569	51,844	291,717	73,105	35,618	10.00
10.01 01001	SNACK BAR	0	0	0	0	0	10.01
11.00 01100	CAFETERIA	27,213	104,306	533,919	133,802	69,611	11.00
13.00 01300	NURSING ADMINISTRATION	12,238	203,146	892,177	223,582	31,306	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	14,536	45,534	427,744	107,194	37,183	14.00
15.00 01500	PHARMACY	13,370	168,968	652,387	163,490	34,200	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	32,270	150,200	738,159	184,985	90,934	16.00
17.00 01700	SOCIAL SERVICE	1,893	21,434	94,342	23,642	4,844	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	204,829	635,586	3,250,385	814,556	523,958	30.00
31.00 03100	INTENSIVE CARE UNIT	54,495	233,556	1,135,546	284,571	139,399	31.00
43.00 04300	NURSERY	18,658	70,804	360,330	90,300	47,727	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	135,383	513,199	2,733,312	684,976	346,313	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	56,896	68,981	419,386	105,099	145,542	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	104,591	473,403	2,988,673	748,970	267,546	54.00
60.00 06000	LABORATORY	48,110	439,166	3,665,574	918,604	176,228	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	12,896	1,268	491,368	123,138	32,989	65.00
66.00 06600	PHYSICAL THERAPY	60,221	90,680	1,183,015	296,467	154,048	66.00
66.01 06601	CARDIAC REHAB	31,692	42,119	238,802	59,844	81,070	66.01
69.00 06900	ELECTROCARDIOLOGY	369	22,464	122,797	30,773	945	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	803	248,835	62,359	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	548,540	137,466	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	541,361	135,667	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	1,588,573	398,101	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00 09100	EMERGENCY	85,391	335,633	1,665,771	417,447	218,432	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	31,381	363,196	1,443,193	361,668	80,273	95.00
99.10 09910	CORF	0	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	155,895	759,301	190,283	81,868	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00 11600	HOSPICE	0	59,202	433,447	108,623	8,860	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,028,295	5,735,976	41,766,831	8,068,591	2,702,486	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	58,894	38,786	593,330	148,690	1,272,167	192.00
192.01 19201	DEKALB MEDICAL SERVICES	0	1,124,237	5,372,898	1,346,451	527,443	192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02 07952	FOUNDATION	0	5,490	25,477	6,385	0	194.02
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)	2,087,189	6,904,489	47,758,536	9,570,117	4,502,096	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150045

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	SNACK BAR	CAFETERIA	
		8.00	9.00	10.00	10.01	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MAC WEST - NEW					1.01
1.02	00102	NORTH ANNEX - NEW					1.02
1.03	00103	GARRETT CLINIC - NEW					1.03
1.04	00104	BUTLER - NEW					1.04
1.05	00105	MAC EAST - NEW					1.05
1.06	00106	GARRETT LAB - NEW					1.06
1.07	00107	MEDICAL ARTS - NEW					1.07
1.08	00108	DAY SPRING - NEW					1.08
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					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	322,088				8.00
9.00	00900	HOUSEKEEPING	17,445	1,224,792			9.00
10.00	01000	DIETARY	3,231	9,895	413,566		10.00
10.01	01001	SNACK BAR	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	19,340	0	0	756,672
13.00	01300	NURSING ADMINISTRATION	0	8,698	0	0	20,149
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,330	0	0	12,135
15.00	01500	PHARMACY	0	9,502	0	0	15,551
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,264	0	0	31,781
17.00	01700	SOCIAL SERVICE	0	1,346	0	0	2,638
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	124,667	145,569	309,400	0	98,434
31.00	03100	INTENSIVE CARE UNIT	28,974	38,729	104,166	0	35,173
43.00	04300	NURSERY	5,143	13,260	0	0	9,321
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	47,282	96,214	0	0	68,612
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	40,435	0	0	9,070
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,616	74,331	0	0	65,372
60.00	06000	LABORATORY	35	48,961	0	0	73,084
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	2,883	9,165	0	0	100
66.00	06600	PHYSICAL THERAPY	4,196	42,798	0	0	15,501
66.01	06601	CARDIAC REHAB	1,366	22,523	0	0	7,587
69.00	06900	ELECTROCARDIOLOGY	0	263	0	0	4,145
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	50
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
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	49,137	60,686	0	0	46,680
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	22,302	0	0	78,210
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	22,745	0	0	23,717
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	179	2,462	0	0	7,612
118.00		SUBTOTALS (SUM OF LINES 1-117)	315,154	724,818	413,566	0	624,922
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,934	353,437	0	0	16,481
192.01	19201	DEKALB MEDICAL SERVICES	0	146,537	0	0	114,138
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	ADULT DAY CARE	0	0	0	0	1,131
194.02	07952	FOUNDATION	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	322,088	1,224,792	413,566	0	756,672

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150045

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00104						1.04
1.05	00105						1.05
1.06	00106						1.06
1.07	00107						1.07
1.08	00108						1.08
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
10.01	01001						10.01
11.00	01100						11.00
13.00	01300	1,175,912					13.00
14.00	01400	42,494	637,080				14.00
15.00	01500	0	4,013	879,143			15.00
16.00	01600	0	3	0	1,071,126		16.00
17.00	01700	10,625	0	0	0	137,437	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	439,625	23,576	0	92,198	137,437	30.00
31.00	03100	130,799	7,037	0	30,005	0	31.00
43.00	04300	0	0	0	9,154	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	244,796	76,640	0	162,892	0	50.00
52.00	05200	0	0	0	18,330	0	52.00
54.00	05400	0	40,997	0	203,062	0	54.00
60.00	06000	23,941	69,441	0	209,227	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	3,130	0	20,855	0	65.00
66.00	06600	0	8,144	0	30,234	0	66.00
66.01	06601	0	469	0	3,750	0	66.01
69.00	06900	0	2,169	0	9,010	0	69.00
70.00	07000	0	21	0	13,123	0	70.00
71.00	07100	0	231,515	0	41,789	0	71.00
72.00	07200	0	26,392	0	18,653	0	72.00
73.00	07300	0	74,473	879,143	64,552	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	175,075	29,814	0	97,738	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	12,614	0	46,554	0	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	82,207	5,430	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	26,350	507	0	0	0	116.00
118.00		1,175,912	616,385	879,143	1,071,126	137,437	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	328	0	0	0	192.00
192.01	19201	0	20,367	0	0	0	192.01
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,175,912	637,080	879,143	1,071,126	137,437	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150045

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

Worksheet B
Part I
Date/Time Prepared:
2/23/2013 9:02 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
1.01	00101				1.01
1.02	00102				1.02
1.03	00103				1.03
1.04	00104				1.04
1.05	00105				1.05
1.06	00106				1.06
1.07	00107				1.07
1.08	00108				1.08
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
10.01	01001				10.01
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	5,959,805	0	5,959,805	30.00
31.00	03100	1,934,399	0	1,934,399	31.00
43.00	04300	535,235	0	535,235	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	4,461,037	0	4,461,037	50.00
52.00	05200	737,862	0	737,862	52.00
54.00	05400	4,419,567	0	4,419,567	54.00
60.00	06000	5,185,095	0	5,185,095	60.00
60.01	06001	0	0	0	60.01
65.00	06500	683,628	0	683,628	65.00
66.00	06600	1,734,403	0	1,734,403	66.00
66.01	06601	415,411	0	415,411	66.01
69.00	06900	170,102	0	170,102	69.00
70.00	07000	324,388	0	324,388	70.00
71.00	07100	959,310	0	959,310	71.00
72.00	07200	722,073	0	722,073	72.00
73.00	07300	3,004,842	0	3,004,842	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	2,760,780	0	2,760,780	91.00
92.00	09200		0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	2,044,814	0	2,044,814	95.00
99.10	09910	0	0	0	99.10
101.00	10100	1,165,551	0	1,165,551	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
116.00	11600	588,040	0	588,040	116.00
118.00		37,806,342	0	37,806,342	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
191.00	19100	0	0	0	191.00
192.00	19200	2,391,367	0	2,391,367	192.00
192.01	19201	7,527,834	0	7,527,834	192.01
193.00	19300	0	0	0	193.00
194.00	07950	0	0	0	194.00
194.01	07951	1,131	0	1,131	194.01
194.02	07952	31,862	0	31,862	194.02
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		47,758,536	0	47,758,536	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150045

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

Worksheet B
Part II
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				GARRETT CLINIC - NEW	
		NEW BLDG & FIXT	MAC WEST - NEW	NORTH ANNEX - NEW			
		1.00	1.01	1.02	1.03		
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01 00101	MAC WEST - NEW					1.01	
1.02 00102	NORTH ANNEX - NEW					1.02	
1.03 00103	GARRETT CLINIC - NEW					1.03	
1.04 00104	BUTLER - NEW					1.04	
1.05 00105	MAC EAST - NEW					1.05	
1.06 00106	GARRETT LAB - NEW					1.06	
1.07 00107	MEDICAL ARTS - NEW					1.07	
1.08 00108	DAY SPRING - NEW					1.08	
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	92,167	0	2,099	5.00	
7.00 00700	OPERATION OF PLANT	0	783,929	10,093	0	7.00	
8.00 00800	LAUNDRY & LINEN SERVICE	0	11,674	0	0	8.00	
9.00 00900	HOUSEKEEPING	0	18,566	0	0	9.00	
10.00 01000	DIETARY	0	9,796	0	0	10.00	
10.01 01001	SNACK BAR	0	0	0	0	10.01	
11.00 01100	CAFETERIA	0	23,044	0	0	11.00	
13.00 01300	NURSING ADMINISTRATION	0	10,364	0	0	13.00	
14.00 01400	CENTRAL SERVICES & SUPPLY	0	12,309	0	0	14.00	
15.00 01500	PHARMACY	0	11,322	0	0	15.00	
16.00 01600	MEDICAL RECORDS & LIBRARY	0	27,326	0	0	16.00	
17.00 01700	SOCIAL SERVICE	0	1,603	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	173,452	0	0	30.00	
31.00 03100	INTENSIVE CARE UNIT	0	46,147	0	0	31.00	
43.00 04300	NURSERY	0	15,799	0	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	114,644	0	0	50.00	
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	48,181	0	0	52.00	
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	88,569	0	0	54.00	
60.00 06000	LABORATORY	0	40,740	2,287	0	60.00	
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01	
65.00 06500	RESPIRATORY THERAPY	0	10,921	0	0	65.00	
66.00 06600	PHYSICAL THERAPY	0	50,996	0	0	66.00	
66.01 06601	CARDIAC REHAB	0	26,838	0	0	66.01	
69.00 06900	ELECTROCARDIOLOGY	0	313	0	0	69.00	
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00	
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00	
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00	
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS							
91.00 09100	EMERGENCY	0	72,310	0	0	91.00	
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	26,574	0	0	95.00	
99.10 09910	CORF	0	0	0	0	99.10	
101.00 10100	HOME HEALTH AGENCY	0	0	0	2,735	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE					113.00	
116.00 11600	HOSPICE	0	0	0	296	116.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,717,584	12,380	5,130	118.00	
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00	
191.00 19100	RESEARCH	0	0	0	0	191.00	
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	49,872	40,055	0	192.00	
192.01 19201	DEKALB MEDICAL SERVICES	0	0	3,812	0	192.01	
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00	
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00	
194.01 07951	ADULT DAY CARE	0	0	0	0	194.01	
194.02 07952	FOUNDATION	0	0	0	0	194.02	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers		0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)	0	1,767,456	56,247	5,130	4,231	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150045

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

Worksheet B
Part II
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description	CAPITAL RELATED COSTS					DAY SPRING - NEW	
	BUTLER - NEW	MAC EAST - NEW	GARRETT LAB - NEW	MEDICAL ARTS - NEW			
	1.04	1.05	1.06	1.07	1.08		
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101	MAC WEST - NEW						1.01
1.02 00102	NORTH ANNEX - NEW						1.02
1.03 00103	GARRETT CLINIC - NEW						1.03
1.04 00104	BUTLER - NEW						1.04
1.05 00105	MAC EAST - NEW						1.05
1.06 00106	GARRETT LAB - NEW						1.06
1.07 00107	MEDICAL ARTS - NEW						1.07
1.08 00108	DAY SPRING - NEW						1.08
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	23,145	0	0	15,683	5.00
7.00 00700	OPERATION OF PLANT	0	51,372	0	4,509	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	350	0	0	0	9.00
10.00 01000	DIETARY	0	941	0	0	0	10.00
10.01 01001	SNACK BAR	0	0	0	0	0	10.01
11.00 01100	CAFETERIA	0	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	1,310	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	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
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 06000	LABORATORY	980	0	3,489	0	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01 06601	CARDIAC REHAB	0	0	0	0	0	66.01
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
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
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10 09910	CORF	0	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
116.00 11600	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	980	77,118	3,489	4,509	15,683	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	59,705	0	43,404	0	192.00
192.01 19201	DEKALB MEDICAL SERVICES	12,880	36,021	13,200	8,953	0	192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02 07952	FOUNDATION	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	13,860	172,844	16,689	56,866	15,683	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150045

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

Worksheet B
Part II
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
	NEW MVBLE EQUIP						
	2.00	2A					
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101	MAC WEST - NEW						1.01
1.02 00102	NORTH ANNEX - NEW						1.02
1.03 00103	GARRETT CLINIC - NEW						1.03
1.04 00104	BUTLER - NEW						1.04
1.05 00105	MAC EAST - NEW						1.05
1.06 00106	GARRETT LAB - NEW						1.06
1.07 00107	MEDICAL ARTS - NEW						1.07
1.08 00108	DAY SPRING - NEW						1.08
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	0			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	108,840	241,934	0	241,934		5.00
7.00 00700	OPERATION OF PLANT	925,744	1,775,647	0	22,806	1,798,453	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	13,785	25,459	0	1,453	14,087	8.00
9.00 00900	HOUSEKEEPING	21,925	40,841	0	5,820	23,301	9.00
10.00 01000	DIETARY	11,569	22,306	0	1,848	14,228	10.00
10.01 01001	SNACK BAR	0	0	0	0	0	10.01
11.00 01100	CAFETERIA	27,213	50,257	0	3,382	27,808	11.00
13.00 01300	NURSING ADMINISTRATION	12,238	22,602	0	5,652	12,506	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	14,536	26,845	0	2,710	14,853	14.00
15.00 01500	PHARMACY	13,370	24,692	0	4,133	13,662	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	32,270	60,906	0	4,676	36,326	16.00
17.00 01700	SOCIAL SERVICE	1,893	3,496	0	598	1,935	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	204,829	378,281	0	20,591	209,306	30.00
31.00 03100	INTENSIVE CARE UNIT	54,495	100,642	0	7,194	55,686	31.00
43.00 04300	NURSERY	18,658	34,457	0	2,283	19,065	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	135,383	250,027	0	17,316	138,342	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	56,896	105,077	0	2,657	58,140	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	104,591	193,160	0	18,933	106,877	54.00
60.00 06000	LABORATORY	48,110	95,606	0	23,221	70,398	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	12,896	23,817	0	3,113	13,178	65.00
66.00 06600	PHYSICAL THERAPY	60,221	111,217	0	7,494	61,538	66.00
66.01 06601	CARDIAC REHAB	31,692	58,530	0	1,513	32,385	66.01
69.00 06900	ELECTROCARDIOLOGY	369	682	0	778	378	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,576	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,475	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	3,430	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,064	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00 09100	EMERGENCY	85,391	157,701	0	10,553	87,257	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	31,381	57,955	0	9,143	32,067	95.00
99.10 09910	CORF	0	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	2,735	0	4,810	32,704	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
116.00 11600	HOSPICE	0	296	0	2,746	3,539	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,028,295	3,865,168	0	203,968	1,079,566	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	58,894	256,161	0	3,759	508,189	192.00
192.01 19201	DEKALB MEDICAL SERVICES	0	74,866	0	34,046	210,698	192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02 07952	FOUNDATION	0	0	0	161	0	194.02
200.00	Cross Foot Adjustments		0				200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,087,189	4,196,195	0	241,934	1,798,453	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150045

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

Worksheet B
Part II
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	SNACK BAR	CAFETERIA	
		8.00	9.00	10.00	10.01	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MAC WEST - NEW					1.01
1.02	00102	NORTH ANNEX - NEW					1.02
1.03	00103	GARRETT CLINIC - NEW					1.03
1.04	00104	BUTLER - NEW					1.04
1.05	00105	MAC EAST - NEW					1.05
1.06	00106	GARRETT LAB - NEW					1.06
1.07	00107	MEDICAL ARTS - NEW					1.07
1.08	00108	DAY SPRING - NEW					1.08
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					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	40,999				8.00
9.00	00900	HOUSEKEEPING	2,221	72,183			9.00
10.00	01000	DIETARY	411	583	39,376		10.00
10.01	01001	SNACK BAR	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	1,140	0	82,587	11.00
13.00	01300	NURSING ADMINISTRATION	0	513	0	2,199	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	609	0	1,324	14.00
15.00	01500	PHARMACY	0	560	0	1,697	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,489	0	3,469	16.00
17.00	01700	SOCIAL SERVICE	0	79	0	288	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,868	8,579	29,458	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,688	2,282	9,918	0	31.00
43.00	04300	NURSERY	655	781	0	1,017	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,019	5,670	0	7,489	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,383	0	990	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,897	4,381	0	7,135	54.00
60.00	06000	LABORATORY	4	2,885	0	7,977	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	367	540	0	11	65.00
66.00	06600	PHYSICAL THERAPY	534	2,522	0	1,692	66.00
66.01	06601	CARDIAC REHAB	174	1,327	0	828	66.01
69.00	06900	ELECTROCARDIOLOGY	0	15	0	452	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5	70.00
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
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	6,255	3,577	0	5,095	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	1,314	0	8,536	95.00
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	1,340	0	2,589	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	23	145	0	831	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	40,116	42,714	39,376	68,207	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	883	20,833	0	1,799	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	8,636	0	12,458	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	123	194.01
194.02	07952	FOUNDATION	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	40,999	72,183	39,376	82,587	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150045

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00104						1.04
1.05	00105						1.05
1.06	00106						1.06
1.07	00107						1.07
1.08	00108						1.08
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
10.01	01001						10.01
11.00	01100						11.00
13.00	01300	43,472					13.00
14.00	01400	1,571	47,912				14.00
15.00	01500	0	302	45,046			15.00
16.00	01600	0	0	0	106,866		16.00
17.00	01700	393	0	0	0	6,789	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	16,253	1,773	0	9,195	6,789	30.00
31.00	03100	4,835	529	0	2,993	0	31.00
43.00	04300	0	0	0	913	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	9,050	5,764	0	16,246	0	50.00
52.00	05200	0	0	0	1,828	0	52.00
54.00	05400	0	3,083	0	20,252	0	54.00
60.00	06000	885	5,222	0	20,905	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	235	0	2,080	0	65.00
66.00	06600	0	613	0	3,015	0	66.00
66.01	06601	0	35	0	374	0	66.01
69.00	06900	0	163	0	899	0	69.00
70.00	07000	0	2	0	1,309	0	70.00
71.00	07100	0	17,411	0	4,168	0	71.00
72.00	07200	0	1,985	0	1,860	0	72.00
73.00	07300	0	5,601	45,046	6,438	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	6,472	2,242	0	9,748	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	949	0	4,643	0	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	3,039	408	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	974	38	0	0	0	116.00
118.00		43,472	46,355	45,046	106,866	6,789	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	25	0	0	0	192.00
192.01	19201	0	1,532	0	0	0	192.01
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		43,472	47,912	45,046	106,866	6,789	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150045

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

Worksheet B
Part II
Date/Time Prepared:
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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
1.01	00101				1.01
1.02	00102				1.02
1.03	00103				1.03
1.04	00104				1.04
1.05	00105				1.05
1.06	00106				1.06
1.07	00107				1.07
1.08	00108				1.08
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
10.01	01001				10.01
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	706,837	0	706,837	30.00
31.00	03100	191,606	0	191,606	31.00
43.00	04300	59,171	0	59,171	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	455,923	0	455,923	50.00
52.00	05200	171,075	0	171,075	52.00
54.00	05400	357,718	0	357,718	54.00
60.00	06000	227,103	0	227,103	60.00
60.01	06001	0	0	0	60.01
65.00	06500	43,341	0	43,341	65.00
66.00	06600	188,625	0	188,625	66.00
66.01	06601	95,166	0	95,166	66.01
69.00	06900	3,367	0	3,367	69.00
70.00	07000	2,892	0	2,892	70.00
71.00	07100	25,054	0	25,054	71.00
72.00	07200	7,275	0	7,275	72.00
73.00	07300	67,149	0	67,149	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	288,900	0	288,900	91.00
92.00	09200		0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	114,607	0	114,607	95.00
99.10	09910	0	0	0	99.10
101.00	10100	47,625	0	47,625	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
116.00	11600	8,592	0	8,592	116.00
118.00		3,062,026	0	3,062,026	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
191.00	19100	0	0	0	191.00
192.00	19200	791,649	0	791,649	192.00
192.01	19201	342,236	0	342,236	192.01
193.00	19300	0	0	0	193.00
194.00	07950	0	0	0	194.00
194.01	07951	123	0	123	194.01
194.02	07952	161	0	161	194.02
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		4,196,195	0	4,196,195	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045

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

Worksheet B-1
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description		CAPITAL RELATED COSTS					BUTLER - NEW (SQUARE FEET)	
		NEW BLDG & FIXT (SQUARE FEET)	MAC WEST - NEW (SQUARE FEET)	NORTH ANNEX - NEW (SQUARE FEET)	GARRETT CLINIC - NEW (SQUARE FEET)			
		1.00	1.01	1.02	1.03	1.04		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	180,779					1.00
1.01	00101	MAC WEST - NEW	0	16,334				1.01
1.02	00102	NORTH ANNEX - NEW	0	0	5,200			1.02
1.03	00103	GARRETT CLINIC - NEW	0	0	0	6,850		1.03
1.04	00104	BUTLER - NEW	0	0	0	0	4,977	1.04
1.05	00105	MAC EAST - NEW	0	0	0	0	0	1.05
1.06	00106	GARRETT LAB - NEW	0	0	0	0	0	1.06
1.07	00107	MEDICAL ARTS - NEW	0	0	0	0	0	1.07
1.08	00108	DAY SPRING - NEW	0	0	0	0	0	1.08
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,427		2,128	0	0	5.00
7.00	00700	OPERATION OF PLANT	80,182	2,931	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,194	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,899	0	0	0	0	9.00
10.00	01000	DIETARY	1,002	0	0	0	0	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	2,357	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,060	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,259	0	0	0	0	14.00
15.00	01500	PHARMACY	1,158	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,795	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	164	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,741	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,720	0	0	0	0	31.00
43.00	04300	NURSERY	1,616	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,726	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,928	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,059	0	0	0	0	54.00
60.00	06000	LABORATORY	4,167	664	0	0	352	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,117	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,216	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	2,745	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	32	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	7,396	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,718	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	2,772	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	300	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	175,678	3,595	5,200	0	352	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,101	11,632	0	6,850	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	1,107	0	0	4,625	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
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)	1,767,456	56,247	5,130	4,231	13,860	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.776888	3.443553	0.986538	0.617664	2.784810	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045

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

Worksheet B-1

Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description	CAPITAL RELATED COSTS					205.00
	NEW BLDG & FIXT (SQUARE FEET)	MAC WEST - NEW (SQUARE FEET)	NORTH ANNEX - NEW (SQUARE FEET)	GARRETT CLINIC - NEW (SQUARE FEET)	BUTLER - NEW (SQUARE FEET)	
	1.00	1.01	1.02	1.03	1.04	
205.00 Unit cost multiplier (Wkst. B, Part 11)						205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045

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

Worksheet B-1

Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description		CAPITAL RELATED COSTS						
		MAC EAST - NEW	GARRETT LAB - NEW	MEDICAL ARTS - NEW	DAY SPRING - NEW	NEW MVBLE EQUIP		
		(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)		
		1.05	1.06	1.07	1.08	2.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	MAC WEST - NEW					1.01	
1.02	00102	NORTH ANNEX - NEW					1.02	
1.03	00103	GARRETT CLINIC - NEW					1.03	
1.04	00104	BUTLER - NEW					1.04	
1.05	00105	MAC EAST - NEW	37,481				1.05	
1.06	00106	GARRETT LAB - NEW	0	3,750			1.06	
1.07	00107	MEDICAL ARTS - NEW	0	0	8,575		1.07	
1.08	00108	DAY SPRING - NEW	0	0	0	18,456	1.08	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				180,779	2.00	
4.00	00400	EMPLOYEE BENEFITS	0	0	0	0	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	5,019	0	0	18,456	5.00	
7.00	00700	OPERATION OF PLANT	11,140	0	680	0	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00	
9.00	00900	HOUSEKEEPING	76	0	0	0	9.00	
10.00	01000	DIETARY	204	0	0	0	10.00	
10.01	01001	SNACK BAR	0	0	0	0	10.01	
11.00	01100	CAFETERIA	0	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00	
15.00	01500	PHARMACY	0	0	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	284	0	0	0	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	17,741	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	4,720	31.00
43.00	04300	NURSERY	0	0	0	0	1,616	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	11,726	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	4,928	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	9,059	54.00
60.00	06000	LABORATORY	0	784	0	0	4,167	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	1,117	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	5,216	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	2,745	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	32	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	7,396	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	2,718	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,723	784	680	18,456	175,678	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,947	0	6,545	0	5,101	192.00
192.01	19201	DEKALB MEDICAL SERVICES	7,811	2,966	1,350	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
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)	172,844	16,689	56,866	15,683	2,087,189	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.611510	4.450400	6.631603	0.849751	11.545528	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045

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

Worksheet B-1

Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description	CAPITAL RELATED COSTS					
	MAC EAST - NEW	GARRETT LAB - NEW	MEDICAL ARTS - NEW	DAY SPRING - NEW	NEW MVBLE EQUIP	
	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	
205.00	1.05	1.06	1.07	1.08	2.00	205.00
Unit cost multiplier (Wkst. B, Part 11)						

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045

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

Worksheet B-1
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)		
		4.00	5A	5.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	MAC WEST - NEW					1.01	
1.02	00102	NORTH ANNEX - NEW					1.02	
1.03	00103	GARRETT CLINIC - NEW					1.03	
1.04	00104	BUTLER - NEW					1.04	
1.05	00105	MAC EAST - NEW					1.05	
1.06	00106	GARRETT LAB - NEW					1.06	
1.07	00107	MEDICAL ARTS - NEW					1.07	
1.08	00108	DAY SPRING - NEW					1.08	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS	22,063,394				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	3,506,573	-9,570,117	38,188,419		5.00	
7.00	00700	OPERATION OF PLANT	576,123	0	3,599,940	152,439	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	119,844	0	229,349	1,194	8.00	
9.00	00900	HOUSEKEEPING	541,482	0	918,771	1,975	9.00	
10.00	01000	DIETARY	165,668	0	291,717	1,206	10.00	
10.01	01001	SNACK BAR	0	0	0	0	10.01	
11.00	01100	CAFETERIA	333,310	0	533,919	2,357	11.00	
13.00	01300	NURSING ADMINISTRATION	649,155	0	892,177	1,060	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	145,504	0	427,744	1,259	14.00	
15.00	01500	PHARMACY	539,938	0	652,387	1,158	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	479,966	0	738,159	3,079	16.00	
17.00	01700	SOCIAL SERVICE	68,493	0	94,342	164	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,031,023	0	3,250,385	17,741	30.00	
31.00	03100	INTENSIVE CARE UNIT	746,332	0	1,135,546	4,720	31.00	
43.00	04300	NURSERY	226,255	0	360,330	1,616	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,639,933	0	2,733,312	11,726	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	220,428	0	419,386	4,928	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,512,765	0	2,988,673	9,059	54.00	
60.00	06000	LABORATORY	1,403,359	0	3,665,574	5,967	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01	
65.00	06500	RESPIRATORY THERAPY	4,051	0	491,368	1,117	65.00	
66.00	06600	PHYSICAL THERAPY	289,770	0	1,183,015	5,216	66.00	
66.01	06601	CARDIAC REHAB	134,592	0	238,802	2,745	66.01	
69.00	06900	ELECTROCARDIOLOGY	71,785	0	122,797	32	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	2,565	0	248,835	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	548,540	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	541,361	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,588,573	0	73.00	
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,072,520	0	1,665,771	7,396	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,160,598	0	1,443,193	2,718	95.00	
99.10	09910	CORF	0	0	0	0	99.10	
101.00	10100	HOME HEALTH AGENCY	498,163	0	759,301	2,772	101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE					113.00	
116.00	11600	HOSPICE	189,181	0	433,447	300	116.00	
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,329,376	-9,570,117	32,196,714	91,505	343,628	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00	
191.00	19100	RESEARCH	0	0	0	0	191.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	123,941	0	593,330	43,075	7,560	192.00
192.01	19201	DEKALB MEDICAL SERVICES	3,592,533	0	5,372,898	17,859	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	17,544	0	25,477	0	0	194.02
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)	6,904,489		9,570,117	4,502,096	322,088	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.312939		0.250603	29.533754	0.917138	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		241,934	1,798,453	40,999	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.006335	11.797854	0.116744	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045

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

Worksheet B-1
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	SNACK BAR (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		9.00	10.00	10.01	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00104						1.04
1.05	00105						1.05
1.06	00106						1.06
1.07	00107						1.07
1.08	00108						1.08
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	149,270					9.00
10.00	01000	1,206	21,094				10.00
10.01	01001	0	0	0			10.01
11.00	01100	2,357	0	0	30,118		11.00
13.00	01300	1,060	0	0	802	225,007	13.00
14.00	01400	1,259	0	0	483	8,131	14.00
15.00	01500	1,158	0	0	619	0	15.00
16.00	01600	3,079	0	0	1,265	0	16.00
17.00	01700	164	0	0	105	2,033	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	17,741	15,781	0	3,918	84,121	30.00
31.00	03100	4,720	5,313	0	1,400	25,028	31.00
43.00	04300	1,616	0	0	371	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	11,726	0	0	2,731	46,841	50.00
52.00	05200	4,928	0	0	361	0	52.00
54.00	05400	9,059	0	0	2,602	0	54.00
60.00	06000	5,967	0	0	2,909	4,581	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	1,117	0	0	4	0	65.00
66.00	06600	5,216	0	0	617	0	66.00
66.01	06601	2,745	0	0	302	0	66.01
69.00	06900	32	0	0	165	0	69.00
70.00	07000	0	0	0	2	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	7,396	0	0	1,858	33,500	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	2,718	0	0	3,113	0	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	2,772	0	0	944	15,730	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	300	0	0	303	5,042	116.00
118.00		88,336	21,094	0	24,874	225,007	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	43,075	0	0	656	0	192.00
192.01	19201	17,859	0	0	4,543	0	192.01
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	45	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00							201.00
202.00		1,224,792	413,566	0	756,672	1,175,912	202.00
203.00		8.205212	19.605859	0.000000	25.123581	5.226113	203.00
204.00		72,183	39,376	0	82,587	43,472	204.00
205.00		0.483573	1.866692	0.000000	2.742114	0.193203	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045

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

Worksheet B-1

Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)		
		14.00	15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00	
1.01	00101	MAC WEST - NEW				1.01	
1.02	00102	NORTH ANNEX - NEW				1.02	
1.03	00103	GARRETT CLINIC - NEW				1.03	
1.04	00104	BUTLER - NEW				1.04	
1.05	00105	MAC EAST - NEW				1.05	
1.06	00106	GARRETT LAB - NEW				1.06	
1.07	00107	MEDICAL ARTS - NEW				1.07	
1.08	00108	DAY SPRING - NEW				1.08	
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				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
10.01	01001	SNACK BAR				10.01	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	1,034,805			14.00	
15.00	01500	PHARMACY	6,519	100		15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	5	0	94,959,024	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	100	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	38,294	0	8,173,573	100	30.00
31.00	03100	INTENSIVE CARE UNIT	11,430	0	2,660,035	0	31.00
43.00	04300	NURSERY	0	0	811,529	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	124,486	0	14,440,799	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,625,008	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,592	0	18,001,949	0	54.00
60.00	06000	LABORATORY	112,792	0	18,549,375	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	5,084	0	1,848,880	0	65.00
66.00	06600	PHYSICAL THERAPY	13,229	0	2,680,337	0	66.00
66.01	06601	CARDIAC REHAB	761	0	332,483	0	66.01
69.00	06900	ELECTROCARDIOLOGY	3,523	0	798,775	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	34	0	1,163,399	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	376,048	0	3,704,664	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	42,868	0	1,653,655	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	120,966	100	5,722,685	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	48,427	0	8,664,757	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	20,489	0	4,127,121	0	95.00
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	8,820	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	823	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,001,190	100	94,959,024	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	533	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	33,082	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	194.02
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)	637,080	879,143	1,071,126	137,437	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.615652	8,791.430000	0.011280	1,374.370000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	47,912	45,046	106,866	6,789	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.046301	450.460000	0.001125	67.890000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150045

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

Worksheet C
Part I
Date/Time Prepared:
2/23/2013 9:02 am

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		5,959,805	0	5,959,805	30.00
31.00	03100 INTENSIVE CARE UNIT		1,934,399	0	1,934,399	31.00
43.00	04300 NURSERY		535,235	0	535,235	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		4,461,037	0	4,461,037	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		737,862	0	737,862	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,419,567	801	4,420,368	54.00
60.00	06000 LABORATORY		5,185,095	12,700	5,197,795	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	683,628	0	683,628	65.00
66.00	06600 PHYSICAL THERAPY	0	1,734,403	0	1,734,403	66.00
66.01	06601 CARDIAC REHAB	0	415,411	989	416,400	66.01
69.00	06900 ELECTROCARDIOLOGY		170,102	0	170,102	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		324,388	0	324,388	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		959,310	0	959,310	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		722,073	0	722,073	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		3,004,842	0	3,004,842	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY		2,760,780	1,448	2,762,228	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,202,741		1,202,741	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		2,044,814	1,149	2,045,963	95.00
99.10	09910 CORF		0		0	99.10
101.00	10100 HOME HEALTH AGENCY		1,165,551		1,165,551	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
116.00	11600 HOSPICE		588,040		588,040	116.00
200.00	Subtotal (see instructions)	0	39,009,083	17,087	39,026,170	200.00
201.00	Less Observation Beds		1,202,741		1,202,741	201.00
202.00	Total (see instructions)	0	37,806,342	17,087	37,823,429	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150045

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

Worksheet C
Part I
Date/Time Prepared:
2/23/2013 9:02 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 VIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,173,573		8,173,573		30.00
31.00	03100	INTENSIVE CARE UNIT	2,660,035		2,660,035		31.00
43.00	04300	NURSERY	811,529		811,529		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,056,649	11,055,438	13,112,087	0.340223	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,608,669	16,339	1,625,008	0.454067	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,372,048	16,629,901	18,001,949	0.245505	54.00
60.00	06000	LABORATORY	2,392,691	16,156,684	18,549,375	0.279529	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	1,202,996	645,884	1,848,880	0.369752	65.00
66.00	06600	PHYSICAL THERAPY	302,671	2,377,665	2,680,336	0.647084	66.00
66.01	06601	CARDIAC REHAB	5,002	327,481	332,483	1.249420	66.01
69.00	06900	ELECTROCARDIOLOGY	112,786	685,989	798,775	0.212954	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,399	1,159,000	1,163,399	0.278828	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,056,506	2,648,158	3,704,664	0.258947	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	769,223	884,432	1,653,655	0.436653	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,916,246	3,806,438	5,722,684	0.525076	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,321,272	7,343,486	8,664,758	0.318622	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	149,472	1,916,201	2,065,673	0.582251	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	4,127,121	4,127,121	0.495458	95.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	920,360	920,360		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	41,080	912,973	954,053		116.00
200.00		Subtotal (see instructions)	25,956,847	71,613,550	97,570,397		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	25,956,847	71,613,550	97,570,397		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150045

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

Worksheet C
Part I
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		11.00			
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.340223			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.454067			52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.245549			54.00
60.00	06000 LABORATORY	0.280214			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
65.00	06500 RESPIRATORY THERAPY	0.369752			65.00
66.00	06600 PHYSICAL THERAPY	0.647084			66.00
66.01	06601 CARDIAC REHAB	1.252395			66.01
69.00	06900 ELECTROCARDIOLOGY	0.212954			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.278828			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.258947			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.436653			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.525076			73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.318789			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.582251			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.495736			95.00
99.10	09910 CORF				99.10
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
116.00	11600 HOSPICE				116.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150045

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

Worksheet C
Part I
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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	5,959,805		5,959,805	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	1,934,399		1,934,399	0	0	31.00
43.00	04300 NURSERY	535,235		535,235	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	4,461,037		4,461,037	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	737,862		737,862	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,419,567		4,419,567	0	0	54.00
60.00	06000 LABORATORY	5,185,095		5,185,095	0	0	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	683,628	0	683,628	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,734,403	0	1,734,403	0	0	66.00
66.01	06601 CARDIAC REHAB	415,411	0	415,411	0	0	66.01
69.00	06900 ELECTROCARDIOLOGY	170,102		170,102	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	324,388		324,388	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	959,310		959,310	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	722,073		722,073	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,004,842		3,004,842	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	2,760,780		2,760,780	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,202,741		1,202,741	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	2,044,814		2,044,814	0	0	95.00
99.10	09910 CORF	0		0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY	1,165,551		1,165,551	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	588,040		588,040			116.00
200.00	Subtotal (see instructions)	39,009,083	0	39,009,083	0	0	200.00
201.00	Less Observation Beds	1,202,741		1,202,741			201.00
202.00	Total (see instructions)	37,806,342	0	37,806,342	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150045

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

Worksheet C
Part I
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		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,173,573		8,173,573		30.00
31.00	03100	INTENSIVE CARE UNIT	2,660,035		2,660,035		31.00
43.00	04300	NURSERY	811,529		811,529		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,056,649	11,055,438	13,112,087	0.340223	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,608,669	16,339	1,625,008	0.454067	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,372,048	16,629,901	18,001,949	0.245505	54.00
60.00	06000	LABORATORY	2,392,691	16,156,684	18,549,375	0.279529	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	1,202,996	645,884	1,848,880	0.369752	65.00
66.00	06600	PHYSICAL THERAPY	302,671	2,377,665	2,680,336	0.647084	66.00
66.01	06601	CARDIAC REHAB	5,002	327,481	332,483	1.249420	66.01
69.00	06900	ELECTROCARDIOLOGY	112,786	685,989	798,775	0.212954	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,399	1,159,000	1,163,399	0.278828	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,056,506	2,648,158	3,704,664	0.258947	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	769,223	884,432	1,653,655	0.436653	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,916,246	3,806,438	5,722,684	0.525076	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,321,272	7,343,486	8,664,758	0.318622	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	149,472	1,916,201	2,065,673	0.582251	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	4,127,121	4,127,121	0.495458	95.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	920,360	920,360		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	41,080	912,973	954,053		116.00
200.00		Subtotal (see instructions)	25,956,847	71,613,550	97,570,397		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	25,956,847	71,613,550	97,570,397		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150045

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

Worksheet C
Part I
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
66.01	06601	CARDIAC REHAB	0.000000		66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 150045		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part I Date/Time Prepared: 2/23/2013 9:02 am	
Cost Center Description			Title XVIII		Hospital		PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	706,837	0	706,837	5,198	135.98	30.00
31.00	03100	INTENSIVE CARE UNIT	191,606		191,606	1,141	167.93	31.00
43.00	04300	NURSERY	59,171		59,171	864	68.48	43.00
200.00		Total (lines 30-199)	957,614		957,614	7,203		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part I Date/Time Prepared: 2/23/2013 9:02 am
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
			6.00	7.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,543	209,817	30.00
31.00	03100	INTENSIVE CARE UNIT	397	66,668	31.00
43.00	04300	NURSERY	0	0	43.00
200.00		Total (lines 30-199)	1,940	276,485	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part II Date/Time Prepared: 2/23/2013 9:02 am
		Title XVIII	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	455,923	13,112,087	0.034771	616,898	21,450	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	171,075	1,625,008	0.105276	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	357,718	18,001,949	0.019871	864,328	17,175	54.00
60.00	06000 LABORATORY	227,103	18,549,375	0.012243	1,315,121	16,101	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	43,341	1,848,880	0.023442	379,352	8,893	65.00
66.00	06600 PHYSICAL THERAPY	188,625	2,680,336	0.070374	99,043	6,970	66.00
66.01	06601 CARDIAC REHAB	95,166	332,483	0.286228	2,234	639	66.01
69.00	06900 ELECTROCARDIOLOGY	3,367	798,775	0.004215	77,477	327	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2,892	1,163,399	0.002486	2,220	6	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25,054	3,704,664	0.006763	497,169	3,362	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	7,275	1,653,655	0.004399	326,226	1,435	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	67,149	5,722,684	0.011734	843,672	9,900	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	288,900	8,664,758	0.033342	488,788	16,297	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	142,646	2,065,673	0.069055	76,057	5,252	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	2,076,234	79,923,726		5,588,585	107,807	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150045		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/23/2013 9:02 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150045		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/23/2013 9:02 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	5,198	0.00	1,543	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	1,141	0.00	397	0	0	31.00
43.00	04300 NURSERY	864	0.00	0	0	0	43.00
200.00	Total (lines 30-199)	7,203		1,940	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150045		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/23/2013 9:02 am	
Cost Center Description		PSA Adj . Allied Health Cost	PSA Adj . All Other Medical Education Cost	Title XVIII	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: 150045

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

Worksheet D
Part IV
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description		Title XVIII				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150045

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	13,112,087	0.000000	0.000000	616,898	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,625,008	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	18,001,949	0.000000	0.000000	864,328	54.00
60.00	06000 LABORATORY	0	18,549,375	0.000000	0.000000	1,315,121	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	1,848,880	0.000000	0.000000	379,352	65.00
66.00	06600 PHYSICAL THERAPY	0	2,680,336	0.000000	0.000000	99,043	66.00
66.01	06601 CARDIAC REHAB	0	332,483	0.000000	0.000000	2,234	66.01
69.00	06900 ELECTROCARDIOLOGY	0	798,775	0.000000	0.000000	77,477	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1,163,399	0.000000	0.000000	2,220	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,704,664	0.000000	0.000000	497,169	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1,653,655	0.000000	0.000000	326,226	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5,722,684	0.000000	0.000000	843,672	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	8,664,758	0.000000	0.000000	488,788	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,065,673	0.000000	0.000000	76,057	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	79,923,726			5,588,585	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150045

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

Worksheet D
Part IV
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
Title XVIII Hospital PPS								
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,314,767	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,081,090	0	0	0	54.00
60.00	06000	LABORATORY	0	499,982	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	91,715	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,491	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	118,152	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	163,354	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	232,282	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	444,777	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	151,326	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,426,074	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	1,121,329	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	451,560	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	10,097,899	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/23/2013 9:02 am
	Title XVIII	Hospital	PPS

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
66.01	06601 CARDIAC REHAB	0	0	66.01
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (Lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150045

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

Worksheet D
Part V
Date/Time Prepared:
2/23/2013 9:02 am

		Title XVIII		Hospital		PPS	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges					
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.340223	2,314,767	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.454067	0	0	0		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.245505	3,081,090	0	0		54.00
60.00	06000 LABORATORY	0.279529	499,982	0	0		60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0		60.01
65.00	06500 RESPIRATORY THERAPY	0.369752	91,715	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0.647084	1,491	0	0		66.00
66.01	06601 CARDIAC REHAB	1.249420	118,152	0	0		66.01
69.00	06900 ELECTROCARDIOLOGY	0.212954	163,354	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.278828	232,282	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.258947	444,777	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.436653	151,326	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.525076	1,426,074	0	4,718		73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0.318622	1,121,329	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.582251	451,560	0	0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.495458		0			95.00
200.00	Subtotal (see instructions)		10,097,899	0	4,718		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		10,097,899	0	4,718		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150045

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

Worksheet D
Part V
Date/Time Prepared:
2/23/2013 9:02 am

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	787,537	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	756,423	0	0		54.00
60.00	06000 LABORATORY	139,759	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
65.00	06500 RESPIRATORY THERAPY	33,912	0	0		65.00
66.00	06600 PHYSICAL THERAPY	965	0	0		66.00
66.01	06601 CARDIAC REHAB	147,621	0	0		66.01
69.00	06900 ELECTROCARDIOLOGY	34,787	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	64,767	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	115,174	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	66,077	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	748,797	0	2,477		73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	357,280	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	262,921	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		0			95.00
200.00	Subtotal (see instructions)	3,516,020	0	2,477		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	3,516,020	0	2,477		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150045

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

Worksheet D
Part V
Date/Time Prepared:
2/23/2013 9:02 am

		Title XIX		Hospital		Cost	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges					
		PPS Reimbursed Services (see inst.)	Cost		Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Subject To Ded. & Coins. (see inst.)			
		1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.340223	0	1,276,132	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.454067	0	4,682	0		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.245505	0	1,626,072	0		54.00
60.00	06000 LABORATORY	0.279529	0	1,633,902	0		60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0		60.01
65.00	06500 RESPIRATORY THERAPY	0.369752	0	84,030	0		65.00
66.00	06600 PHYSICAL THERAPY	0.647084	0	420,986	0		66.00
66.01	06601 CARDIAC REHAB	1.249420	0	10,340	0		66.01
69.00	06900 ELECTROCARDIOLOGY	0.212954	0	45,358	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.278828	0	166,787	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.258947	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.436653	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.525076	0	271,827	0		73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0.318622	0	1,301,535	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.582251	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.495458	0	497,679	0		95.00
200.00	Subtotal (see instructions)		0	7,339,330	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	7,339,330	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/23/2013 9:02 am
		Title XIX	Hospital	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	434,169	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,126	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	399,209	0	54.00
60.00	06000	LABORATORY	0	456,723	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	31,070	0	65.00
66.00	06600	PHYSICAL THERAPY	0	272,413	0	66.00
66.01	06601	CARDIAC REHAB	0	12,919	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	9,659	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	46,505	0	70.00
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	142,730	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	414,698	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		246,579		95.00
200.00		Subtotal (see instructions)	0	2,468,800	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	2,468,800	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 2/23/2013 9:02 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)		5,198	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,198	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,149	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,543	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,959,805	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,959,805	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		11,108,152	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		11,108,152	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.536525	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)		2,677.31	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,959,805	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)		1,146.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,769,142	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)		1,769,142	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150045		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 2/23/2013 9:02 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)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,934,399	1,141	1,695.35	397	673,054		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)					1,929,188		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,371,384		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)					276,485		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					107,807		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					384,292		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,987,092		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					1,049		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,146.56		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,202,741		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150045		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/23/2013 9:02 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	706,837	5,959,805	0.118601	1,202,741	142,646	90.00
91.00	Nursing School cost	0	5,959,805	0.000000	1,202,741	0	91.00
92.00	Allied health cost	0	5,959,805	0.000000	1,202,741	0	92.00
93.00	All other Medical Education	0	5,959,805	0.000000	1,202,741	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1 Date/Time Prepared: 2/23/2013 9:02 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			5,198 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			5,198 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			4,149 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			165 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)			864 15.00
16.00	Nursery days (title V or XIX only)			34 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			5,959,805 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			5,959,805 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			11,108,152 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			11,108,152 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.536525 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)			2,677.31 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			5,959,805 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)			1,146.56 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			189,182 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)			189,182 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1 Date/Time Prepared: 2/23/2013 9:02 am		
Cost Center Description			Title XIX	Hospital	Cost		
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	NURSERY (title V & XIX only)	535,235	864	619.48	34	21,062	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,934,399	1,141	1,695.35	46	77,986	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)					731,471	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,019,701	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)						0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,049	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,146.56	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,202,741	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150045		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/23/2013 9:02 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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/23/2013 9:02 am
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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		2,652,217	30.00
31.00	03100	INTENSIVE CARE UNIT		1,076,671	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.340223	616,898	209,883 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.454067	0	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.245549	864,328	212,235 54.00
60.00	06000	LABORATORY	0.280214	1,315,121	368,515 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0.369752	379,352	140,266 65.00
66.00	06600	PHYSICAL THERAPY	0.647084	99,043	64,089 66.00
66.01	06601	CARDIAC REHAB	1.252395	2,234	2,798 66.01
69.00	06900	ELECTROCARDIOLOGY	0.212954	77,477	16,499 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.278828	2,220	619 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.258947	497,169	128,740 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.436653	326,226	142,448 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.525076	843,672	442,992 73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.318789	488,788	155,820 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.582251	76,057	44,284 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			
200.00		Total (sum of lines 50-94 and 96-98)		5,588,585	1,929,188 200.00
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)		5,588,585	1,929,188 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/23/2013 9:02 am
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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		944,379	30.00
31.00	03100	INTENSIVE CARE UNIT		133,599	31.00
43.00	04300	NURSERY		390,308	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.340223	338,505	115,167 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.454067	706,588	320,838 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.245505	65,753	16,143 54.00
60.00	06000	LABORATORY	0.279529	259,135	72,436 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0.369752	95,042	35,142 65.00
66.00	06600	PHYSICAL THERAPY	0.647084	57,321	37,092 66.00
66.01	06601	CARDIAC REHAB	1.249420	1,033	1,291 66.01
69.00	06900	ELECTROCARDIOLOGY	0.212954	3,734	795 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.278828	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.258947	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.436653	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.525076	204,102	107,169 73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.318622	79,712	25,398 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.582251	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			
200.00		Total (sum of lines 50-94 and 96-98)		1,810,925	731,471 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		1,810,925	731,471 202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part A Date/Time Prepared: 2/23/2013 9:02 am
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		2,646,888	1.00
2.00	Outlier payments for discharges. (see instructions)		32,788	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		44.13	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.65	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		23.97	31.00
32.00	Sum of lines 30 and 31		25.62	32.00
33.00	Allowable disproportionate share percentage (see instructions)		10.35	33.00
34.00	Disproportionate share adjustment (see instructions)		273,953	34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		2,953,629	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part A Date/Time Prepared: 2/23/2013 9:02 am
		Title XVIII	Hospital	PPS
		before 1/1	on/after 1/1	
		1.00	1.01	
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	2,953,629		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	215,108		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)	0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).	0		52.00
53.00	Nursing and Allied Health Managed Care payment	0		53.00
54.00	Special add-on payments for new technologies	0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)	0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)	0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).	0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	0		58.00
59.00	Total (sum of amounts on lines 49 through 58)	3,168,737		59.00
60.00	Primary payer payments	2,415		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	3,166,322		61.00
62.00	Deductibles billed to program beneficiaries	459,280		62.00
63.00	Coinsurance billed to program beneficiaries	8,929		63.00
64.00	Allowable bad debts (see instructions)	9,648		64.00
65.00	Adjusted reimbursable bad debts (see instructions)	6,754		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	9,648		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	2,704,867		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)	0		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)	0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		70.00
70.95	Recovery of Accelerated Depreciation	0		70.95
70.96	Low Volume Payment-1	514,455		70.96
70.97	Low Volume Payment-2	0		70.97
70.98	Low Volume Payment-3	0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	3,219,322		71.00
72.00	Interim payments	3,255,582		72.00
73.00	Tentative settlement (for contractor use only)	0		73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)	-36,260		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2	43,674		75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)	0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2	0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)	0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)	0		93.00
94.00	The rate used to calculate the Time Value of Money	0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)	0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)	0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/23/2013 9:02 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,477	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,516,020	2.00
3.00	PPS payments		2,466,576	3.00
4.00	Outlier payment (see instructions)		10,230	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.851	5.00
6.00	Line 2 times line 5		2,992,133	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		82.78	7.00
8.00	Transitional corridor payment (see instructions)		438,028	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)		2,477	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		4,718	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)		4,718	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)		4,718	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,241	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)		2,477	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)		2,914,834	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		622,170	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		2,295,141	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,295,141	30.00
31.00	Primary payer payments		252	31.00
32.00	Subtotal (line 30 minus line 31)		2,294,889	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)		74,772	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		52,340	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		74,772	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		2,347,229	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		2,347,229	40.00
41.00	Interim payments		2,399,169	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)		-51,940	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: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/23/2013 9:02 am
	Title XVIII	Hospital	PPS
			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: 150045

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

Worksheet E-1
Part I
Date/Time Prepared:
2/23/2013 9:02 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		3,255,582		2,399,169	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,255,582		2,399,169	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		36,260		51,940	6.02	
7.00	Total Medicare program liability (see instructions)		3,219,322		2,347,229	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: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet E-1 Part II Date/Time Prepared: 2/23/2013 9:02 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			1,890 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,940 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			813 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			5,290 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			97,570,397 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			874,000 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,127,979 8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,040,914 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			87,065 32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0 108.00

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

Provider CCN: 150045

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

Worksheet G

Date/Time Prepared:
2/23/2013 9:02 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	0	0	0	0	1.00
2.00	Temporary investments	15,473,760	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,187,704	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-862,642	0	0	0	6.00
7.00	Inventory	1,324,144	0	0	0	7.00
8.00	Prepaid expenses	1,040,979	0	0	0	8.00
9.00	Other current assets	1,010,961	0	0	0	9.00
10.00	Due from other funds	142,811	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	26,317,717	0	0	0	11.00
FIXED ASSETS						
12.00	Land	393,118	0	0	0	12.00
13.00	Land improvements	1,955,099	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	53,782,651	0	0	0	15.00
16.00	Accumulated depreciation	-39,275,626	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	23,502,531	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)	40,357,773	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,394,445	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,394,445	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	68,069,935	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,773,900	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,025,630	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,155,533	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	1,278,404	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,233,467	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	9,403,556	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,403,556	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,637,023	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	50,432,912	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	50,432,912	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	68,069,935	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150045

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

Worksheet G-1

Date/Time Prepared:
2/23/2013 9:02 am

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
1.00	Fund balances at beginning of period		47,071,518		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		3,311,557			2.00
3.00	Total (sum of line 1 and line 2)		50,383,075		0	3.00
4.00	NET ASSETS RELEASED FROM RESTRICTION	53,844		0		4.00
5.00	CONTRIBUTIONS RECEIVED	76,699		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)		130,543		0	10.00
11.00	Subtotal (line 3 plus line 10)		50,513,618		0	11.00
12.00	NET ASSETS RELEASED FROM RESTRICTION	80,706		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)		80,706		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		50,432,912		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150045

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

Worksheet G-1

Date/Time Prepared:
2/23/2013 9:02 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 NET ASSETS RELEASED FROM RESTRICTION	0		0			4.00
5.00 CONTRIBUTIONS RECEIVED	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 NET ASSETS RELEASED FROM RESTRICTION	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: 150045

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	11,108,152		11,108,152	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)	11,108,152		11,108,152	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,108,152		11,108,152	17.00
18.00	Ancillary services	14,972,173	80,838,011	95,810,184	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	0	0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	26,080,325	80,838,011	106,918,336	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		52,230,594		29.00
30.00	EXPENSES NOT INCLUDED ON WORKSHEET A	4,525,484			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)		4,525,484		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)		56,756,078		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150045

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

Worksheet G-3

Date/Time Prepared:
2/23/2013 9:02 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	106,918,336	1.00
2.00	Less contractual allowances and discounts on patients' accounts	57,441,972	2.00
3.00	Net patient revenues (line 1 minus line 2)	49,476,364	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	56,756,078	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,279,714	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	MISCELLANEOUS INCOME	10,591,271	24.00
25.00	Total other income (sum of lines 6-24)	10,591,271	25.00
26.00	Total (line 5 plus line 25)	3,311,557	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)	3,311,557	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150045

Period: From 10/01/2011

Worksheet H

HHA CCN: 157157

To 09/30/2012

Date/Time Prepared: 2/23/2013 9:02 am

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		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	34,640	0	0	4.00
5.00	Administrative and General	225,662	0	0	0	65,275	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	129,002	0	0	0	0	6.00
7.00	Physical Therapy	86,505	0	0	2,782	0	7.00
8.00	Occupational Therapy	0	0	0	9,671	0	8.00
9.00	Speech Pathology	1,275	0	0	0	0	9.00
10.00	Medical Social Services	7,433	0	0	0	0	10.00
11.00	Home Health Aide	15,179	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	4,702	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	22,750	0	5,403	0	22	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)	487,806	0	40,043	12,453	69,999	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: 150045

Period: From 10/01/2011

Worksheet H

HHA CCN: 157157

To 09/30/2012

Date/Time Prepared: 2/23/2013 9:02 am

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	Total (sum of col. 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	34,640	0	34,640	0	34,640	4.00
5.00 Administrative and General	290,937	17,913	308,850	-27,543	281,307	5.00
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	129,002	0	129,002	0	129,002	6.00
7.00 Physical Therapy	89,287	0	89,287	0	89,287	7.00
8.00 Occupational Therapy	9,671	0	9,671	0	9,671	8.00
9.00 Speech Pathology	1,275	0	1,275	0	1,275	9.00
10.00 Medical Social Services	7,433	0	7,433	0	7,433	10.00
11.00 Home Health Aide	15,179	0	15,179	0	15,179	11.00
12.00 Supplies (see instructions)	4,702	0	4,702	0	4,702	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	28,175	0	28,175	0	28,175	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)	610,301	17,913	628,214	-27,543	600,671	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: 150045 HHA CCN: 157157	Period: From 10/01/2011 To 09/30/2012	Worksheet H-1 Part I Date/Time Prepared: 2/23/2013 9:02 am
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	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	34,640	0	0	0	4.00
5.00	Administrative and General	281,307	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	129,002	0	0	0	6.00
7.00	Physical Therapy	89,287	0	0	0	7.00
8.00	Occupational Therapy	9,671	0	0	0	8.00
9.00	Speech Pathology	1,275	0	0	0	9.00
10.00	Medical Social Services	7,433	0	0	0	10.00
11.00	Home Health Aide	15,179	0	0	0	11.00
12.00	Supplies (see instructions)	4,702	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	28,175	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)	600,671	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 150045	Period: From 10/01/2011	Worksheet H-1
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	Subtotal (col s. 0-4) 4A.00	Administrative & General 5.00	Total (col s. 4A + 5) 6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures	0		1.00
2.00	Capital Related - Movable Equipment	0		2.00
3.00	Plant Operation & Maintenance	0		3.00
4.00	Transportation			4.00
5.00	Administrative and General	281,307	281,307	5.00
HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	148,373	130,691	279,064
7.00	Physical Therapy	93,816	82,636	176,452
8.00	Occupational Therapy	9,671	8,519	18,190
9.00	Speech Pathology	1,295	1,141	2,436
10.00	Medical Social Services	7,840	6,906	14,746
11.00	Home Health Aide	20,829	18,347	39,176
12.00	Supplies (see instructions)	4,702	4,142	8,844
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	32,838	28,925	61,763
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)	600,671		600,671

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 150045
HHA CCN: 157157

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

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		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation			
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)						
		1.00	2.00				3.00	4.00	5A.00
GENERAL SERVICE COST CENTERS									
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00		
2.00	Capital Related - Movable Equipment		0			0	2.00		
3.00	Plant Operation & Maintenance	0	0	0		0	3.00		
4.00	Transportation (see instructions)	0	0	0	40,133		4.00		
5.00	Administrative and General	0	0	0	0	-281,307	5.00		
HHA REIMBURSABLE SERVICES									
6.00	Skilled Nursing Care	0	0	0	22,443	0	6.00		
7.00	Physical Therapy	0	0	0	5,247	0	7.00		
8.00	Occupational Therapy	0	0	0	0	0	8.00		
9.00	Speech Pathology	0	0	0	23	0	9.00		
10.00	Medical Social Services	0	0	0	471	0	10.00		
11.00	Home Health Aide	0	0	0	6,546	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	5,403	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	40,133	-281,307	24.00		
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	34,640		25.00		
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.863130		26.00		

COST ALLOCATION - HHA STATISTICAL BASIS	Provider CCN: 150045	Period: From 10/01/2011	Worksheet H-1 Part II Date/Time Prepared: 2/23/2013 9:02 am
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		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	319,364	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	148,373	6.00
7.00	Physical Therapy	93,816	7.00
8.00	Occupational Therapy	9,671	8.00
9.00	Speech Pathology	1,295	9.00
10.00	Medical Social Services	7,840	10.00
11.00	Home Health Aide	20,829	11.00
12.00	Supplies (see instructions)	4,702	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	32,838	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)	319,364	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	281,307	25.00
26.00	Unit Cost Multiplier	0.880835	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet H-2 Part I Date/Time Prepared: 2/23/2013 9:02 am
		HHA CCN: 157157	Home Health Agency I	PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			GARRETT CLINIC - NEW	
		NEW BLDG & FIXT	MAC WEST - NEW	NORTH ANNEX - NEW		
	0	1.00	1.01	1.02	1.03	
1.00 Administrative and General	0	0	0	2,735	0	1.00
2.00 Skilled Nursing Care	279,064	0	0	0	0	2.00
3.00 Physical Therapy	176,452	0	0	0	0	3.00
4.00 Occupational Therapy	18,190	0	0	0	0	4.00
5.00 Speech Pathology	2,436	0	0	0	0	5.00
6.00 Medical Social Services	14,746	0	0	0	0	6.00
7.00 Home Health Aide	39,176	0	0	0	0	7.00
8.00 Supplies (see instructions)	8,844	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	61,763	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)	600,671	0	0	2,735	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: 150045
HHA CCN: 157157

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

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Cost Center Description	CAPITAL RELATED COSTS					DAY SPRING - NEW	1.08	
	BUTLER - NEW	MAC EAST - NEW	GARRETT LAB - NEW	MEDICAL ARTS - NEW				
	1.04	1.05	1.06	1.07				
1.00 Administrative and General	0	0	0	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	0	0	0	0	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.								21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150045
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS 4.00	Subtotal 4A	ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	
	NEW	MVBLE EQUIP					
	2.00	2.00					
1.00 Administrative and General	0	0	72,191	74,926	18,777	81,868	1.00
2.00 Skilled Nursing Care	0	0	41,269	320,333	80,276	0	2.00
3.00 Physical Therapy	0	0	27,674	204,126	51,155	0	3.00
4.00 Occupational Therapy	0	0	0	18,190	4,558	0	4.00
5.00 Speech Pathology	0	0	408	2,844	713	0	5.00
6.00 Medical Social Services	0	0	2,378	17,124	4,291	0	6.00
7.00 Home Health Aide	0	0	4,856	44,032	11,035	0	7.00
8.00 Supplies (see instructions)	0	0	0	8,844	2,216	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	7,119	68,882	17,262	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	0	0	155,895	759,301	190,283	81,868	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: 150045
HHA CCN: 157157

Period:
From 10/01/2011
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Part I
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Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	SNACK BAR	CAFETERIA	
	8.00	9.00	10.00	10.01	11.00	
1.00 Administrative and General	0	22,745	0	0	23,717	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	0	22,745	0	0	23,717	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: 150045
HHA CCN: 157157

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

Worksheet H-2
Part I
Date/Time Prepared:
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Cost Center Description		NURSING	CENTRAL	PHARMACY	MEDICAL	SOCIAL SERVICE	
		ADMINISTRATION	SERVICES & SUPPLY		RECORDS & LIBRARY		
		13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	74,817	5,430	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	7,390	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)	82,207	5,430	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet H-2 Part I Date/Time Prepared: 2/23/2013 9:02 am
		HHA CCN: 157157	Home Health Agency I	PPS

Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
	24.00	25.00	26.00	27.00	28.00	
1.00 Administrative and General	302,280	0	302,280			1.00
2.00 Skilled Nursing Care	400,609	0	400,609	140,275	540,884	2.00
3.00 Physical Therapy	255,281	0	255,281	89,388	344,669	3.00
4.00 Occupational Therapy	22,748	0	22,748	7,965	30,713	4.00
5.00 Speech Pathology	3,557	0	3,557	1,246	4,803	5.00
6.00 Medical Social Services	21,415	0	21,415	7,499	28,914	6.00
7.00 Home Health Aide	55,067	0	55,067	19,282	74,349	7.00
8.00 Supplies (see instructions)	11,060	0	11,060	3,873	14,933	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	93,534	0	93,534	32,752	126,286	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)	1,165,551	0	1,165,551	302,280	1,165,551	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.				0.350157		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: 150045
HHA CCN: 157157

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

Worksheet H-2
Part II
Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS					BUTLER - NEW (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)	MAC WEST - NEW (SQUARE FEET)	NORTH ANNEX - NEW (SQUARE FEET)	GARRETT CLINIC - NEW (SQUARE FEET)			
	1.00	1.01	1.02	1.03	1.04		
1.00 Administrative and General	0	0	2,772	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	2,772	0	0	0	20.00
21.00 Total cost to be allocated	0	0	2,735	0	0	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.986652	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150045
HHA CCN: 157157

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

Worksheet H-2
Part II
Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS					
	MAC EAST - NEW	GARRETT LAB - NEW	MEDICAL ARTS - NEW	DAY SPRING - NEW	NEW MVBLE EQUIP	
	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	
	1.05	1.06	1.07	1.08	2.00	
1.00 Administrative and General	0	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	0	0	0	20.00
21.00 Total cost to be allocated	0	0	0	0	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150045
HHA CCN: 157157

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

Worksheet H-2
Part II
Date/Time Prepared:
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Home Health Agency I

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Cost Center Description		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		4.00	5A	5.00	7.00	8.00	
1.00	Administrative and General	230,688	0	74,926	2,772	0	1.00
2.00	Skilled Nursing Care	131,875	0	320,333	0	0	2.00
3.00	Physical Therapy	88,432	0	204,126	0	0	3.00
4.00	Occupational Therapy	0	0	18,190	0	0	4.00
5.00	Speech Pathology	1,303	0	2,844	0	0	5.00
6.00	Medical Social Services	7,598	0	17,124	0	0	6.00
7.00	Home Health Aide	15,517	0	44,032	0	0	7.00
8.00	Supplies (see instructions)	0	0	8,844	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	22,750	0	68,882	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)	498,163		759,301	2,772	0	20.00
21.00	Total cost to be allocated	155,895		190,283	81,868	0	21.00
22.00	Unit cost multiplier	0.312940		0.250603	29.533911	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150045
HHA CCN: 157157

Period:
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To 09/30/2012

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Part II
Date/Time Prepared:
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Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	SNACK BAR (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
	9.00	10.00	10.01	11.00	13.00	
1.00 Administrative and General	2,772	0	0	944	14,316	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	1,414	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)	2,772	0	0	944	15,730	20.00
21.00 Total cost to be allocated	22,745	0	0	23,717	82,207	21.00
22.00 Unit cost multiplier	8.205267	0.000000	0.000000	25.123941	5.226128	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150045
HHA CCN: 157157

Period:
From 10/01/2011
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Worksheet H-2
Part II
Date/Time Prepared:
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Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	
	14.00	15.00	16.00	17.00	
1.00 Administrative and General	8,820	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	6.00
7.00 Home Health Aide	0	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)	8,820	0	0	0	20.00
21.00 Total cost to be allocated	5,430	0	0	0	21.00
22.00 Unit cost multiplier	0.615646	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150045 HHA CCN: 157157		Period: From 10/01/2011 To 09/30/2012		Worksheet H-3 Parts I-II Date/Time Prepared: 2/23/2013 9:02 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	540,884		540,884	3,298	1.00
2.00	Physical Therapy	3.00	344,669	0	344,669	1,089	2.00
3.00	Occupational Therapy	4.00	30,713	0	30,713	117	3.00
4.00	Speech Pathology	5.00	4,803	0	4,803	50	4.00
5.00	Medical Social Services	6.00	28,914		28,914	65	5.00
6.00	Home Health Aide	7.00	74,349		74,349	760	6.00
7.00	Total (sum of lines 1-6)		1,024,332	0	1,024,332	5,379	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	652	802		8.00
9.00	Physical Therapy		99915	233	272		9.00
10.00	Occupational Therapy		99915	12	18		10.00
11.00	Speech Pathology		99915	13	5		11.00
12.00	Medical Social Services		99915	8	17		12.00
13.00	Home Health Aide		99915	118	217		13.00
14.00	Total (sum of lines 8-13)			1,036	1,331		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	14,933	0	14,933	7,048	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	0.647084	0	0	1.00
1.01	Physical Therapy 1		66.01	1.249420	0	0	1.01
2.00	Occupational Therapy						2.00
3.00	Speech Pathology						3.00
4.00	Cost of Medical Supplies		71.00	0.258947	0	0	4.00
5.00	Cost of Drugs		73.00	0.525076	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150045 HHA CCN: 157157	Period: From 10/01/2011 To 09/30/2012	Worksheet H-3 Parts I-III Date/Time Prepared: 2/23/2013 9:02 am	
		Title XVIII	Home Health Agency I	PPS	
Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Program Visits		
			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	164.00	652	802	1.00
2.00	Physical Therapy	316.50	233	272	2.00
3.00	Occupational Therapy	262.50	12	18	3.00
4.00	Speech Pathology	96.06	13	5	4.00
5.00	Medical Social Services	444.83	8	17	5.00
6.00	Home Health Aide	97.83	118	217	6.00
7.00	Total (sum of lines 1-6)		1,036	1,331	7.00
Cost Center Description					
		5.00	6.00	7.00	8.00
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		
			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	2.118757			15.00
16.00	Cost of Drugs	0.000000		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	
1.01	Physical Therapy 1	col. 2, line 2.01		1.01	
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: 150045
HHA CCN: 157157

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

Worksheet H-3
Parts I-III
Date/Time Prepared:
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Title XVII

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	106,928	131,528	238,456	1.00
2.00	Physical Therapy	73,745	86,088	159,833	2.00
3.00	Occupational Therapy	3,150	4,725	7,875	3.00
4.00	Speech Pathology	1,249	480	1,729	4.00
5.00	Medical Social Services	3,559	7,562	11,121	5.00
6.00	Home Health Aide	11,544	21,229	32,773	6.00
7.00	Total (sum of lines 1-6)	200,175	251,612	451,787	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: 150045 HHA CCN: 157157	Period: From 10/01/2011 To 09/30/2012	Worksheet H-4 Part I-II Date/Time Prepared: 2/23/2013 9:02 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	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			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		162,855	183,538
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	1,167
13.00	Total PPS Reimbursement - LUPA Episodes		3,449	7,375
14.00	Total PPS Reimbursement - PEP Episodes		1,884	547
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	15
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)		168,188	192,642
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		168,188	192,642
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		168,188	192,642
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)		168,188	192,642
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		168,188	192,642
32.00	Interim payments (see instructions)		168,188	192,642
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: 150045
HHA CCN: 157157

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

Worksheet H-5
Date/Time Prepared:
2/23/2013 9:02 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		168,188		192,642	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)		168,188		192,642	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)		168,188		192,642	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: 150045

Period: From 10/01/2011

Worksheet K

Hospice CCN: 151559

To 09/30/2012

Date/Time Prepared: 2/23/2013 9:02 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	47,872	0	167	74,871	16,389	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	91,928	0	8,326	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	30,855	0	2,622	0	0	15.00
16.00	Spiritual Counseling	3,304	0	1,035	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	12,899	0	5,665	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	33,929	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	40,282	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	323	0	429	35.00
36.00	Volunteer Program Costs	0	0	0	0	8	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)	186,858	0	18,138	74,871	91,037	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150045

Period: From 10/01/2011

Worksheet K

Hospice CCN: 151559

To 09/30/2012

Date/Time Prepared: 2/23/2013 9:02 am

		Hospice I					
		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	139,299	3,141	142,440	-96	142,344	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	100,254	0	100,254	0	100,254	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	33,477	0	33,477	0	33,477	15.00
16.00	Spiritual Counseling	4,339	0	4,339	0	4,339	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	18,564	0	18,564	0	18,564	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	33,929	0	33,929	0	33,929	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	40,282	0	40,282	0	40,282	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	752	0	752	0	752	35.00
36.00	Volunteer Program Costs	8	0	8	0	8	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)	370,904	3,141	374,045	-96	373,949	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150045
 Hospice CCN: 151559

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

Worksheet K-1
 Date/Time Prepared:
 2/23/2013 9:02 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	15,320	8,080	0	20,699	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	91,928	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	30,855	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)	15,320	8,080	30,855	20,699	91,928	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150045

Period: From 10/01/2011

Worksheet K-1

Hospice CCN: 151559

To 09/30/2012

Date/Time Prepared: 2/23/2013 9:02 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	3,773	47,872	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	91,928	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	30,855	15.00
16.00	Spiritual Counseling		0	3,304	3,304	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		12,899	0	12,899	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	12,899	7,077	186,858	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES		Provider CCN: 150045		Period:		Worksheet K-3	
		Hospice CCN: 151559		From 10/01/2011 To 09/30/2012		Date/Time Prepared: 2/23/2013 9:02 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	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES	Provider CCN: 150045 Hospice CCN: 151559	Period: From 10/01/2011 To 09/30/2012	Worksheet K-3 Date/Time Prepared: 2/23/2013 9:02 am
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		Total Therapists	Aides	All-Other	Hospice I Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	74,871	74,871	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	0	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	0	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	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	74,871	74,871	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150045
 Hospice CCN: 151559

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

Worksheet K-4
 Part I
 Date/Time Prepared:
 2/23/2013 9:02 am

		CAPITAL RELATED COST					
		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	142,344	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	100,254	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	33,477	0	0	0	0	15.00
16.00	Spiritual Counseling	4,339	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	18,564	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	33,929	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	40,282	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	752	0	0	0	0	35.00
36.00	Volunteer Program Costs	8	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)	373,949	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150045

Period: From 10/01/2011

Worksheet K-4

Hospice CCN: 151559

To 09/30/2012

Part I
Date/Time Prepared:
2/23/2013 9:02 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	142,344	142,344		6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	0	100,254	61,616	161,870	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	33,477	20,575	54,052	15.00
16.00	Spiritual Counseling	0	4,339	2,667	7,006	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	18,564	11,409	29,973	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	33,929	20,853	54,782	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	40,282	24,757	65,039	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	752	462	1,214	35.00
36.00	Volunteer Program Costs	0	8	5	13	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	373,949		373,949	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045
 Hospice CCN: 151559

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

Worksheet K-4
 Part II
 Date/Time Prepared:
 2/23/2013 9:02 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	283			3.00
4.00	Transportation - Staff	0	0	0	17,971		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	146	8,326	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	49	2,622	0	15.00
16.00	Spiritual Counseling	0	0	0	1,035	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	88	5,665	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	323	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: 150045
 Hospice CCN: 151559

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

Worksheet K-4
 Part II
 Date/Time Prepared:
 2/23/2013 9:02 am

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-142,344	231,605	6.00
INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0	7.00
8.00	Inpatient - Respite Care	0	0	8.00
VISITING SERVICES				
9.00	Physician Services	0	0	9.00
10.00	Nursing Care	0	100,254	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	33,477	15.00
16.00	Spiritual Counseling	0	4,339	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	18,564	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	33,929	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	40,282	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	752	35.00
36.00	Volunteer Program Costs	0	8	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)		142,344	39.00
40.00	Unit Cost Multiplier		0.614598	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150045

Period: From 10/01/2011

Worksheet K-5

Hospice CCN: 151559

To 09/30/2012

Part I
Date/Time Prepared:
2/23/2013 9:02 am

Hospice I

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS			GARRETT CLINIC - NEW	1.03
		NEW BLDG & FIXT	MAC WEST - NEW	NORTH ANNEX - NEW		
		1.00	1.01	1.02		
1.00 Administrative and General	0	0	0	296	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	161,870	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	54,052	0	0	0	0	10.00
11.00 Spiritual Counseling	7,006	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	29,973	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	54,782	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	65,039	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	1,214	0	0	0	0	30.00
31.00 Volunteer Program Costs	13	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)	373,949	0	0	296	0	34.00
35.00 Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150045

Period: From 10/01/2011

Worksheet K-5

Hospice CCN: 151559

To 09/30/2012

Part I
Date/Time Prepared:
2/23/2013 9:02 am

Hospice I

Cost Center Description	CAPITAL RELATED COSTS					DAY SPRING - NEW	
	BUTLER - NEW	MAC EAST - NEW	GARRETT LAB - NEW	MEDICAL ARTS - NEW			
	1.04	1.05	1.06	1.07	1.08		
1.00 Administrative and General	0	0	0	0	0	0	1.00
2.00 Inpatient - General Care	0	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	0	0	0	0	0	34.00
35.00 Unit Cost Multiplier (see instructions)							35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150045

Period: From 10/01/2011

Worksheet K-5

Hospice CCN: 151559

To 09/30/2012

Part I
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		NEW MVBLE EQUIP						
		2.00	4.00	4A	5.00	7.00		
1.00	Administrative and General	0	15,167	15,463	3,875	8,860	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	29,125	190,995	47,864	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	9,776	63,828	15,995	0	10.00	
11.00	Spiritual Counseling	0	1,047	8,053	2,018	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	4,087	34,060	8,536	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	54,782	13,729	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	65,039	16,299	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	1,214	304	0	30.00	
31.00	Volunteer Program Costs	0	0	13	3	0	31.00	
32.00	Fundraising	0	0	0	0	0	32.00	
33.00	Other Program Costs	0	0	0	0	0	33.00	
34.00	Total (sum of lines 1 thru 33) (2)	0	59,202	433,447	108,623	8,860	34.00	
35.00	Unit Cost Multiplier (see instructions)			0.000000			35.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150045

Period:

Worksheet K-5

Hospice CCN: 151559

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

Part I
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description		Hospice I					
		LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	SNACK BAR 10.01	CAFETERIA 11.00	
1.00	Administrative and General	179	2,462	0	0	7,612	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 - Specif y	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	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)	179	2,462	0	0	7,612	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150045

Period:

Worksheet K-5

Hospice CCN: 151559

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

Part I
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description		Hospice I					
		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	26,350	507	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	26,350	507	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: 150045

Period: From 10/01/2011

Worksheet K-5

Hospice CCN: 151559

To 09/30/2012

Part I
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description		Hospice I					
		Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	65,308					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	238,859	0	238,859	29,842	268,701	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	79,823	0	79,823	9,973	89,796	10.00
11.00	Spiritual Counseling	10,071	0	10,071	1,258	11,329	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	42,596	0	42,596	5,322	47,918	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	68,511	0	68,511	8,559	77,070	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	81,338	0	81,338	10,162	91,500	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	1,518	0	1,518	190	1,708	30.00
31.00	Volunteer Program Costs	16	0	16	2	18	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)	588,040	0	588,040		588,040	34.00
35.00	Unit Cost Multiplier (see instructions)				0.124936		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150045
Hospice CCN: 151559

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

Worksheet K-5
Part II
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description		CAPITAL RELATED COSTS				BUTLER - NEW (SQUARE FEET)	
		NEW BLDG & FIXT (SQUARE FEET)	MAC WEST - NEW (SQUARE FEET)	NORTH ANNEX - NEW (SQUARE FEET)	GARRETT CLINIC - NEW (SQUARE FEET)		
		1.00	1.01	1.02	1.03		
1.00	Administrative and General	0	0	300	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	300	0	0	34.00
35.00	Total cost to be allocated	0	0	296	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.986667	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150045
Hospice CCN: 151559

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

Worksheet K-5
Part II
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description		CAPITAL RELATED COSTS					
		MAC EAST - NEW	GARRETT LAB - NEW	MEDICAL ARTS - NEW	DAY SPRING - NEW	NEW MVBLE EQUIP	
		(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	
		1.05	1.06	1.07	1.08	2.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	0	34.00
35.00	Total cost to be allocated	0	0	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150045

Period:

Worksheet K-5

Hospice CCN: 151559

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

Part II
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	Hospice I	
							4.00	5A
1.00	Administrative and General	47,872	0	15,463	300	195	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	91,928	0	190,995	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	30,855	0	63,828	0	0	10.00	
11.00	Spiritual Counseling	3,304	0	8,053	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	12,899	0	34,060	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	54,782	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	65,039	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	1,214	0	0	30.00	
31.00	Volunteer Program Costs	0	0	13	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)	186,858		433,447	300	195	34.00	
35.00	Total cost to be allocated	59,202		108,623	8,860	179	35.00	
36.00	Unit Cost Multiplier (see instructions)	0.316829		0.250603	29.533333	0.917949	36.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150045
Hospice CCN: 151559

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

Worksheet K-5
Part II
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description		Hospice I					
		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	SNACK BAR (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		9.00	10.00	10.01	11.00	13.00	
1.00	Administrative and General	300	0	0	303	5,042	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)	300	0	0	303	5,042	34.00
35.00	Total cost to be allocated	2,462	0	0	7,612	26,350	35.00
36.00	Unit Cost Multiplier (see instructions)	8.206667	0.000000	0.000000	25.122112	5.226101	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150045
Hospice CCN: 151559

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

Worksheet K-5
Part II
Date/Time Prepared:
2/23/2013 9:02 am

Cost Center Description		Hospice I					
		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)		
		14.00	15.00	16.00	17.00		
1.00	Administrative and General	823	0	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)	823	0	0	0		34.00
35.00	Total cost to be allocated	507	0	0	0		35.00
36.00	Unit Cost Multiplier (see instructions)	0.616039	0.000000	0.000000	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 150045

Period: From 10/01/2011

Worksheet K-5

Hospice CCN: 151559

To 09/30/2012

Part III
Date/Time Prepared:
2/23/2013 9:02 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	0.647084	0	0 1.00
1.01	CARDIAC REHAB	66.01	1.252395	0	0 1.01
2.00	OCCUPATIONAL THERAPY	67.00			0 2.00
3.00	SPEECH PATHOLOGY	68.00			0 3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.525076	0	0 4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00			0 5.00
6.00	LABORATORY	60.00	0.280214	0	0 6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0 6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.258947	0	0 7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00			0 8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00			0 9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00			0 10.00
11.00	Totals (sum of lines 1-10)				0 11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 150045

Period: From 10/01/2011

Worksheet K-6

Hospice CCN: 151559

To 09/30/2012

Date/Time Prepared: 2/23/2013 9:02 am

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				588,040	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				4,690	2.00
3.00	Average cost per diem (line 1 divided by line 2)				125.38	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	4,452				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	558,192				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)			238		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			29,840		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150045	Period: From 10/01/2011 To 09/30/2012	Worksheet L Parts I-III Date/Time Prepared: 2/23/2013 9:02 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		211,314	1.00
2.00	Capital DRG outlier payments		3,794	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		14.76	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		215,108	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00