

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: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/28/2013 11:52 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/28/2013	Time: 11:52 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARGARET MARY COMMUNITY HOSPITAL (151329) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title 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	557,791	-549,393	118,455	612,846	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	557,791	-549,393	118,455	612,846	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: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/28/2013 9:24 am
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1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 Zip Code: 47006-		4.00 County: RIPLEY		1.00
1.00	Street: 321 MITCHELL	State: IN		Zip Code: 47006-		County: RIPLEY		2.00
2.00	City: BATESVILLE	State: IN		Zip Code: 47006-		County: RIPLEY		

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	MARGARET MARY COMMUNITY HOSPITAL	151329	99915	1	01/07/1966	N	O	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	MARGARET MARY COMMUNITY HOSPITAL	157143	99915		03/01/1985	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	MARGARET MARY COMMUNITY HOSPITAL	151551	99915		12/31/2003				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2012	12/31/2012	20.00
21.00	Type of Control (see instructions)	2		21.00

Inpatient PPS Information				
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		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.	0		23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	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	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: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/28/2013 9:24 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	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00		0.00	61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
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: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-2
Part I
Date/Time Prepared:
5/28/2013 9:24 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: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/28/2013 9:24 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 report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
		V		XIX		
		1.00		2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical		Occupational		
		1.00		2.00		
		Speech		Respiratory		
		3.00		4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N		N		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
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.	N				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: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/28/2013 9:24 am	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0		0
				1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		Y	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151329			Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/28/2013 9:24 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)						1,084,507	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/28/2013 9:24 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		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
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	02/02/2013	Y	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		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		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		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		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-2
Part II
Date/Time Prepared:
5/28/2013 9:24 am

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been 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.			Y	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			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.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
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.	LISA		ROONEY	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7943		LROONEY@BLUEANDCO.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	02/02/2013	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)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2013 9:24 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Visi ts / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	18	6,588	131,496.00	0	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					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		18	6,588	131,496.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	7	2,562	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,150	131,496.00	0	14.00
15.00 CAH visits					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	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPI CE	116.00	0	0			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00
Component	I/P Days / O/P Visi ts / Tri ps			Full Time Equival ents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payrol l	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	2,238	316	4,960			1.00
2.00 HMO	586	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,238	316	4,960			7.00
8.00 INTENSIVE CARE UNIT	313	7	519			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	925			13.00
14.00 Total (see instructions)	2,551	323	6,404	0.00	465.38	14.00
15.00 CAH visits	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	5,490	1,126	10,380	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPI CE	0	0	0	0.00	0.00	24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2013 9:24 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title VIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
27.00	Total (sum of lines 14-26)			0.00	465.38	27.00
28.00		0	746			28.00
29.00	0					29.00
30.00			0			30.00
31.00			0			31.00
32.00		0	0			32.00
33.00	0					33.00
Component	Full Time Equivalents	Discharges				
	Nonpaid Workers	Title V	Title VIII	Title XIX	Total All Patients	
	11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	718	94	1,797	1.00
2.00	HMO		167			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	718	94	1,797	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				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE	0.00				24.00
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00	Total (sum of lines 14-26)	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

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 151329 Component CCN: 157143		Period: From 01/01/2012 To 12/31/2012		Worksheet S-4 Date/Time Prepared: 5/28/2013 9:24 am	
				Home Health Agency I		PPS	
						1.00	
0.00	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	0	0	0	0	
2.00	Unduplicated Census Count (see instructions)	0.00	342.00	0.00	0.00	0.00	
				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	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00	
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	
5.00	Other Administrative Personnel			0.00	0.00	0.00	
6.00	Direct Nursing Service			0.00	0.00	0.00	
7.00	Nursing Supervisor			0.00	0.00	0.00	
8.00	Physical Therapy Service			0.00	0.00	0.00	
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	
10.00	Occupational Therapy Service			0.00	0.00	0.00	
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	
12.00	Speech Pathology Service			0.00	0.00	0.00	
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	
14.00	Medical Social Service			0.00	0.00	0.00	
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	
16.00	Home Health Aide			0.00	0.00	0.00	
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	
18.00	Other (specify)			0.00	0.00	0.00	
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			17140			
20.01				99915			
				Full Episodes			
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	2,835	0	217	31	3,083	
22.00	Skilled Nursing Visit Charges	474,776	0	36,384	5,176	516,336	
23.00	Physical Therapy Visits	1,446	0	11	17	1,474	
24.00	Physical Therapy Visit Charges	291,052	0	2,222	3,434	296,708	
25.00	Occupational Therapy Visits	477	0	2	6	485	
26.00	Occupational Therapy Visit Charges	102,762	0	432	1,296	104,490	
27.00	Speech Pathology Visits	32	0	0	0	32	
28.00	Speech Pathology Visit Charges	6,966	0	0	0	6,966	
29.00	Medical Social Service Visits	6	0	0	0	6	
30.00	Medical Social Service Visit Charges	1,920	0	0	0	1,920	
31.00	Home Health Aide Visits	404	0	2	4	410	
32.00	Home Health Aide Visit Charges	39,861	0	198	396	40,455	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,200	0	232	58	5,490	
34.00	Other Charges	0	0	0	0	0	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	917,337	0	39,236	10,302	966,875	
36.00	Total Number of Episodes (standard/non outlier)	379		88	4	471	
37.00	Total Number of Outlier Episodes		0		0	0	
38.00	Total Non-Routine Medical Supply Charges	32,534	0	3,030	0	35,564	

HOSPITAL IDENTIFICATION DATA

Provider CCN: 151329
Component CCN: 151551

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-9
Parts I & II
Date/Time Prepared:
5/28/2013 9:24 am

		Hospice I						
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of col.s. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
PART I - ENROLLMENT DAYS								
1.00	Continuous Home Care	0	0	0	0	0	0	
2.00	Routine Home Care	8,488	167	4,079	41	511	9,166	
3.00	Inpatient Respite Care	8	0	0	0	0	8	
4.00	General Inpatient Care	2	4	0	0	5	11	
5.00	Total Hospice Days	8,498	171	4,079	41	516	9,185	
Part II - CENSUS DATA								
6.00	Number of Patients Receiving Hospice Care	93	5	55	3	16	114	
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	58.00		0.00				
8.00	Average Length of Stay (line 5/line 6)	91.38	34.20	74.16	13.67	32.25	80.57	
9.00	Unduplicated Census Count	93	5	52	3	16	114	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-10

Date/Time Prepared:
5/28/2013 9:24 am

				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.417129	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			3,066,953	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				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			10,744,328	6.00
7.00	Medicaid cost (line 1 times line 6)			4,481,771	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)			1,414,818	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)			1,414,818	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,814,229	0	1,814,229	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	756,768	0	756,768	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)	756,768	0	756,768	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?				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)			6,533,475	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			207,507	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)			6,325,968	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)			2,638,745	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			3,395,513	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			4,810,331	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet A
Date/Time Prepared:
5/28/2013 9:24 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		3,487,338	3,487,338	-11,792	3,475,546	1.00
1.01	00101		269,144	269,144	11,792	280,936	1.01
2.00	00200		3,094,545	3,094,545	-101,039	2,993,506	2.00
2.01	00201		0	0	101,039	101,039	2.01
4.00	00400	174,745	9,201,680	9,376,425	0	9,376,425	4.00
5.00	00500	3,799,485	6,165,647	9,965,132	189,754	10,154,886	5.00
7.00	00700	0	1,343,499	1,343,499	0	1,343,499	7.00
7.01	00701	0	64,179	64,179	0	64,179	7.01
7.02	00702	567,385	12,656	580,041	0	580,041	7.02
8.00	00800	83,395	51,970	135,365	0	135,365	8.00
9.00	00900	615,333	148,157	763,490	0	763,490	9.00
10.00	01000	730,302	447,774	1,178,076	-920,516	257,560	10.00
11.00	01100	0	0	0	920,516	920,516	11.00
13.00	01300	640,563	17,900	658,463	0	658,463	13.00
14.00	01400	0	421,993	421,993	0	421,993	14.00
15.00	01500	497,333	1,516,652	2,013,985	0	2,013,985	15.00
16.00	01600	765,681	163,431	929,112	0	929,112	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,589,954	130,384	1,720,338	484,386	2,204,724	30.00
31.00	03100	430,507	17,999	448,506	0	448,506	31.00
43.00	04300	0	20,004	20,004	551,913	571,917	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,187,417	2,379,499	3,566,916	-965,217	2,601,699	50.00
52.00	05200	932,148	201,377	1,133,525	-1,036,299	97,226	52.00
54.00	05400	1,930,068	3,783,070	5,713,138	0	5,713,138	54.00
60.00	06000	1,149,600	1,728,901	2,878,501	0	2,878,501	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	619,485	82,116	701,601	-78,312	623,289	65.00
66.00	06600	814,573	54,580	869,153	0	869,153	66.00
67.00	06700	460,700	73,618	534,318	0	534,318	67.00
68.00	06800	162,658	5,588	168,246	-44,114	124,132	68.00
69.00	06900	271,218	275,532	546,750	78,312	625,062	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	990,225	990,225	72.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	805,918	189,220	995,138	0	995,138	90.00
90.01	09001	199,808	133,156	332,964	0	332,964	90.01
91.00	09100	1,578,544	1,783,183	3,361,727	0	3,361,727	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	1,150,057	238,403	1,388,460	0	1,388,460	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		0	0	0	0	113.00
116.00	11600	527,223	249,847	777,070	0	777,070	116.00
118.00		21,684,100	37,753,042	59,437,142	170,648	59,607,790	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	5,790,609	1,673,609	7,464,218	0	7,464,218	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	176,976	503,476	680,452	-214,762	465,690	194.00
194.01	07951	287,737	89,231	376,968	0	376,968	194.01
194.02	07952	0	0	0	44,114	44,114	194.02
194.03	07953	15,298	42,765	58,063	0	58,063	194.03
200.00		27,954,720	40,062,123	68,016,843	0	68,016,843	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet A
Date/Time Prepared:
5/28/2013 9:24 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	-1,186,596	2,288,950	1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	0	280,936	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-168,356	2,825,150	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	101,039	2.01
4.00	00400	EMPLOYEE BENEFITS	0	9,376,425	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-272,781	9,882,105	5.00
7.00	00700	OPERATION OF PLANT	0	1,343,499	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	64,179	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	580,041	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	-906	134,459	8.00
9.00	00900	HOUSEKEEPING	0	763,490	9.00
10.00	01000	DIETARY	-38,553	219,007	10.00
11.00	01100	CAFETERIA	-219,613	700,903	11.00
13.00	01300	NURSING ADMINISTRATION	0	658,463	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	421,993	14.00
15.00	01500	PHARMACY	0	2,013,985	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-13,354	915,758	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,204,724	30.00
31.00	03100	INTENSIVE CARE UNIT	0	448,506	31.00
43.00	04300	NURSERY	0	571,917	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,601,699	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	97,226	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-392,636	5,320,502	54.00
60.00	06000	LABORATORY	0	2,878,501	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	623,289	65.00
66.00	06600	PHYSICAL THERAPY	0	869,153	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	534,318	67.00
68.00	06800	SPEECH PATHOLOGY	0	124,132	68.00
69.00	06900	ELECTROCARDIOLOGY	-159,214	465,848	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	990,225	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	995,138	90.00
90.01	09001	WOUND CLINIC	0	332,964	90.01
91.00	09100	EMERGENCY	-1,521,433	1,840,294	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	1,388,460	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	777,070	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,973,442	55,634,348	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,464,218	192.00
192.01	19201	PRIVATE DUTY	0	0	192.01
194.00	07950	COMMUNITY RELATIONS	0	465,690	194.00
194.01	07951	COMMUNITY BENEFITS	0	376,968	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	44,114	194.02
194.03	07953	EMS	0	58,063	194.03
200.00		TOTAL (SUM OF LINES 118-199)	-3,973,442	64,043,401	200.00

RECLASSIFICATIONS

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-6

Date/Time Prepared:
5/28/2013 9:24 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	570,638	349,878	1.00
	TOTALS		570,638	349,878	
B - OB RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	398,332	86,054	1.00
2.00	NURSERY	43.00	453,863	98,050	2.00
	TOTALS		852,195	184,104	
C - COMMUNITY RELATIONS					
1.00	ADMINISTRATIVE & GENERAL	5.00	61,942	152,820	1.00
	TOTALS		61,942	152,820	
D - DEPRECIATION RECLASS					
1.00	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	11,792	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP OFFSITE	2.01	0	101,039	2.00
	TOTALS		0	112,831	
E - IMPLANTABLE SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	990,225	1.00
	TOTALS		0	990,225	
F - SPEECH THERAPY					
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.02	42,649	1,465	1.00
	TOTALS		42,649	1,465	
G - ANESTHESIA MEDICAL DIRECTOR					
1.00	OPERATING ROOM	50.00	0	25,008	1.00
	TOTALS		0	25,008	
H - RT EXPENSE RECLASS					
1.00	ELECTROCARDIOLOGY	69.00	78,312	0	1.00
	TOTALS		78,312	0	
500.00	Grand Total: Increases		1,605,736	1,816,331	500.00

RECLASSIFICATIONS

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-6

Date/Time Prepared:
5/28/2013 9:24 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	570,638	349,878	0		1.00
	TOTALS		570,638	349,878			
B - OB RECLASS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	852,195	184,104	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		852,195	184,104			
C - COMMUNITY RELATIONS							
1.00	COMMUNITY RELATIONS	194.00	61,942	152,820	0		1.00
	TOTALS		61,942	152,820			
D - DEPRECIATION RECLASS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	11,792	9		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	101,039	9		2.00
	TOTALS		0	112,831			
E - IMPLANTABLE SUPPLIES							
1.00	OPERATING ROOM	50.00	0	990,225	0		1.00
	TOTALS		0	990,225			
F - SPEECH THERAPY							
1.00	SPEECH PATHOLOGY	68.00	42,649	1,465	0		1.00
	TOTALS		42,649	1,465			
G - ANESTHESIA MEDICAL DIRECTOR							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	25,008	0		1.00
	TOTALS		0	25,008			
H - RT EXPENSE RECLASS							
1.00	RESPIRATORY THERAPY	65.00	78,312	0	0		1.00
	TOTALS		78,312	0			
500.00	Grand Total: Decreases		1,605,736	1,816,331			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-7
Part I
Date/Time Prepared:
5/28/2013 9:24 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,371,158	0	0	0	1.00
2.00	Land Improvements	372,269	0	0	5,835	2.00
3.00	Buildings and Fixtures	60,579,038	8,066,266	0	8,066,266	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	6,337,858	1,635,837	0	1,635,837	5.00
6.00	Movable Equipment	31,462,822	3,487,542	0	3,487,542	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	101,123,145	13,189,645	0	13,189,645	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	101,123,145	13,189,645	0	13,189,645	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,371,158	0			1.00
2.00	Land Improvements	366,434	0			2.00
3.00	Buildings and Fixtures	68,459,646	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	6,410,956	0			5.00
6.00	Movable Equipment	30,999,926	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	108,608,120	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	108,608,120	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-7
Part II
Date/Time Prepared:
5/28/2013 9:24 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,103,811	0	1,383,527	0	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	269,144	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3,094,545	0	0	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	5,467,500	0	1,383,527	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3,487,338				1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	269,144				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	3,094,545				2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0				2.01
3.00	Total (sum of lines 1-2)	0	6,851,027				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-7
Part III
Date/Time Prepared:
5/28/2013 9:24 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	0.000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,092,019	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	280,936	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,825,150	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	101,039	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	5,299,144	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	196,931	0	0	0	2,288,950	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	0	280,936	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,825,150	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	101,039	2.01
3.00	Total (sum of lines 1-2)	196,931	0	0	0	5,496,075	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-8

Date/Time Prepared:
5/28/2013 9:24 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 #	Wkst. A-7	Ref.
			1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00		0 1.00
1.01 Investment income - NEW CAP REL COSTS-OFFSITE BLDG (chapter 2)			ONEW CAP REL COSTS-OFFSITE BLDG	1.01		0 1.01
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00		0 2.00
2.01 Investment income - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01		0 2.01
3.00 Investment income - other (chapter 2)		0		0.00		0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00		0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00		0 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00		0 7.00
8.00 Television and radio service (chapter 21)		0		0.00		0 8.00
9.00 Parking lot (chapter 21)		0		0.00		0 9.00
10.00 Provider-based physician adjustment	A-8-2	-2,068,443				0 10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00		0 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0				0 12.00
13.00 Laundry and linen service		0		0.00		0 13.00
14.00 Cafeteria-employees and guests		0		0.00		0 14.00
15.00 Rental of quarters to employee and others		0		0.00		0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00		0 16.00
17.00 Sale of drugs to other than patients		0		0.00		0 17.00
18.00 Sale of medical records and abstracts		0		0.00		0 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00		0 19.00
20.00 Vending machines		0		0.00		0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		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		0 26.00
26.01 Depreciation - NEW CAP REL COSTS-OFFSITE BLDG			ONEW CAP REL COSTS-OFFSITE BLDG	1.01		0 26.01
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00		0 27.00
27.01 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT			ONEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01		0 27.01
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0	0.00		0 29.00

30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		67.00		30.00			
				Basis/Code (2)	Amount				Cost Center	Line #	Wkst. A-7 Ref.
					OCCUPATIONAL THERAPY						
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			OSPEECH PATHOLOGY	68.00		31.00			
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-168,356		NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00			
33.00	OTHEROPERATING GIRLS ON THE RUN REVE	B	-29,157		ADMINISTRATIVE & GENERAL	5.00	0	33.00			
34.00	OTHEROPERATING OTHOP - INTERNAL SALE	B	356		ADMINISTRATIVE & GENERAL	5.00	0	34.00			
35.00	OTHEROPERATING 24 HOUR FLOWER	B	-722		ADMINISTRATIVE & GENERAL	5.00	0	35.00			
36.00	MMCH OTHER OPERATING COMMBENEFITS SC	B	-1,189		ADMINISTRATIVE & GENERAL	5.00	0	36.00			
37.00	OTHEROPERATING DIABETES PROGRAM	B	-16,189		ADMINISTRATIVE & GENERAL	5.00	0	37.00			
38.00	OTHEROPERATING OTHOP-COMMUNITY CLASS	B	-11,304		ADMINISTRATIVE & GENERAL	5.00	0	38.00			
39.00	OTHEROPERATING OTHOP-PURCHASE DISCOU	B	-1,308		ADMINISTRATIVE & GENERAL	5.00	0	39.00			
40.00	OTHEROPERATING OTHOP - MISC REVENUE	B	-7,075		ADMINISTRATIVE & GENERAL	5.00	0	40.00			
41.00	NON-OPERATING R OTHOP-MISC REVEUE	B	-138		ADMINISTRATIVE & GENERAL	5.00	0	41.00			
43.00	OTHEROPERATING OTHOP - LAUNDRY SERVI	B	-906		LAUNDRY & LINEN SERVICE	8.00	0	43.00			
44.00	OTHEROPERATING OTHOP - VENDING SALES	B	-5,572		DIETARY	10.00	0	44.00			
45.00	OTHEROPERATING OTHOP - DIET SUPP/INS	B	-32,981		DIETARY	10.00	0	45.00			
45.01	CAFETERIA OFFSET	A	-219,613		CAFETERIA	11.00	0	45.01			
45.02	OTHEROPERATING OTHOP - MEDRED TRANSC	B	-13,354		MEDICAL RECORDS & LIBRARY	16.00	0	45.02			
45.03	OTHEROPERATING OTHOP - EMS EDUCATION	B	-4,840		EMERGENCY	91.00	0	45.03			
45.04	INTEREST OFFSET	A	-1,186,596		NEW CAP REL COSTS-BLDG & FIXT	1.00	11	45.04			
45.05	TELEPHONE & TV OFFSET	A	-3,084		ADMINISTRATIVE & GENERAL	5.00	0	45.05			
45.06	LOBBYING EXPENSE	A	-4,607		ADMINISTRATIVE & GENERAL	5.00	0	45.06			
45.07	MEDICAL STAFF RETENTION COST	A	-190,607		ADMINISTRATIVE & GENERAL	5.00	0	45.07			
45.08	MEDICAL STAFF PLACEMENT FEE	A	-7,757		ADMINISTRATIVE & GENERAL	5.00	0	45.08			
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,973,442					50.00			

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-8-2

Date/Time Prepared:
5/28/2013 9:24 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	12,000	0	12,000	0	0	1.00
2.00	43.00	NURSERY	20,004	0	20,004	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	484,636	392,636	92,000	0	0	3.00
4.00	60.00	LABORATORY	72,960	0	72,960	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	197,206	159,214	37,992	0	0	5.00
6.00	91.00	EMERGENCY	1,795,577	1,516,593	278,984	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,582,383	2,068,443	513,940			200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	43.00	NURSERY	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	1.00
2.00	43.00	NURSERY	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	392,636	3.00
4.00	60.00	LABORATORY	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	159,214	5.00
6.00	91.00	EMERGENCY	0	0	0	1,516,593	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
200.00			0	0	0	2,068,443	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
5/28/2013 9:24 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSITE		
		1.00	1.01	2.00	2.01		
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	2,288,950	2,288,950				1.00	
1.01 00101 NEW CAP REL COSTS-OFFSITE BLDG	280,936	0	280,936			1.01	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	2,825,150			2,825,150		2.00	
2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSITE	101,039			0	101,039	2.01	
4.00 00400 EMPLOYEE BENEFITS	9,376,425	23,468	0	28,966	0	4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	9,882,105	358,276	0	442,204	0	5.00	
7.00 00700 OPERATION OF PLANT	1,343,499	365,149	0	450,690	0	7.00	
7.01 00701 OPERATION OF PLANT -OFFSITE	64,179	0	0	0	0	7.01	
7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS	580,041	0	0	0	0	7.02	
8.00 00800 LAUNDRY & LINEN SERVICE	134,459	28,767	0	35,506	0	8.00	
9.00 00900 HOUSEKEEPING	763,490	29,222	0	36,067	0	9.00	
10.00 01000 DIETARY	219,007	18,411	0	22,724	0	10.00	
11.00 01100 CAFETERIA	700,903	65,817	0	81,235	0	11.00	
13.00 01300 NURSING ADMINISTRATION	658,463	0	0	0	0	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	421,993	21,788	0	26,891	0	14.00	
15.00 01500 PHARMACY	2,013,985	15,444	0	19,061	0	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	915,758	34,354	0	42,402	0	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	2,204,724	208,943	0	257,889	0	30.00	
31.00 03100 INTENSIVE CARE UNIT	448,506	34,127	0	42,122	0	31.00	
43.00 04300 NURSERY	571,917	10,644	0	13,137	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	2,601,699	39,956	0	49,317	0	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	97,226	17,987	0	22,201	0	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	5,320,502	301,604	0	372,256	0	54.00	
60.00 06000 LABORATORY	2,878,501	74,992	0	92,560	0	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
65.00 06500 RESPIRATORY THERAPY	623,289	26,360	0	32,535	0	65.00	
66.00 06600 PHYSICAL THERAPY	869,153	46,921	0	57,913	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	534,318	16,503	0	20,369	0	67.00	
68.00 06800 SPEECH PATHOLOGY	124,132	7,495	0	9,250	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	465,848	50,691	0	62,566	0	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	990,225	28,480	0	35,151	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	995,138	140,052	0	172,860	0	90.00	
90.01 09001 WOUND CLINIC	332,964	9,357	0	11,549	0	90.01	
91.00 09100 EMERGENCY	1,840,294	127,304	0	157,125	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00 10100 HOME HEALTH AGENCY	1,388,460	51,706	0	63,818	0	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00 11300 INTEREST EXPENSE						113.00	
116.00 11600 HOSPICE	777,070	0	0	0	0	116.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	55,634,348	2,153,818	0	2,658,364	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00 19200 PHYSICIANS' PRIVATE OFFICES	7,464,218	116,887	280,936	144,268	101,039	192.00	
192.01 19201 PRIVATE DUTY	0	0	0	0	0	192.01	
194.00 07950 COMMUNITY RELATIONS	465,690	6,344	0	7,830	0	194.00	
194.01 07951 COMMUNITY BENEFITS	376,968	11,901	0	14,688	0	194.01	
194.02 07952 OTHER NONREIMBURSABLE COST CENTERS	44,114	0	0	0	0	194.02	
194.03 07953 EMS	58,063	0	0	0	0	194.03	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers		0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)	64,043,401	2,288,950	280,936	2,825,150	101,039	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
5/28/2013 9:24 am

Cost Center Description			EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
			4.00	4A	5.00	7.00	7.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS	9,428,859					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,310,615	11,993,200	11,993,200			5.00
7.00	00700	OPERATION OF PLANT	0	2,159,338	497,546	2,656,884		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	64,179	14,788	0	78,967	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	192,577	772,618	178,024	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	28,305	227,037	52,313	49,565	0	8.00
9.00	00900	HOUSEKEEPING	208,851	1,037,630	239,087	50,347	0	9.00
10.00	01000	DIETARY	54,192	314,334	72,428	31,721	0	10.00
11.00	01100	CAFETERIA	193,681	1,041,636	240,010	113,399	0	11.00
13.00	01300	NURSING ADMINISTRATION	217,415	875,878	201,816	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	470,672	108,450	37,539	0	14.00
15.00	01500	PHARMACY	168,801	2,217,291	510,899	26,608	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	259,881	1,252,395	288,572	59,191	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	674,848	3,346,404	771,065	359,997	0	30.00
31.00	03100	INTENSIVE CARE UNIT	146,119	670,874	154,580	58,800	0	31.00
43.00	04300	NURSERY	154,047	749,745	172,753	18,339	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	403,024	3,093,996	712,906	68,843	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,137	164,551	37,915	30,991	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	655,088	6,649,450	1,532,140	519,649	0	54.00
60.00	06000	LABORATORY	390,188	3,436,241	791,765	129,208	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	183,681	865,865	199,509	45,417	0	65.00
66.00	06600	PHYSICAL THERAPY	276,476	1,250,463	288,127	80,843	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	156,367	727,557	167,641	28,435	0	67.00
68.00	06800	SPEECH PATHOLOGY	40,732	181,609	41,846	12,913	0	68.00
69.00	06900	ELECTROCARDIOLOGY	118,635	697,740	160,770	87,338	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,053,856	242,825	49,069	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	273,538	1,581,588	364,423	241,303	0	90.00
90.01	09001	WOUND CLINIC	67,817	421,687	97,163	16,122	0	90.01
91.00	09100	EMERGENCY	535,777	2,660,500	613,022	219,337	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	390,343	1,894,327	436,483	89,086	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	178,946	956,016	220,281	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,307,081	52,828,677	9,409,147	2,424,060	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,965,405	10,072,753	2,320,924	201,390	78,967	192.00
192.01	19201	PRIVATE DUTY	0	0	0	0	0	192.01
194.00	07950	COMMUNITY RELATIONS	39,044	518,908	119,565	10,930	0	194.00
194.01	07951	COMMUNITY BENEFITS	97,661	501,218	115,489	20,504	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	14,476	58,590	13,500	0	0	194.02
194.03	07953	EMS	5,192	63,255	14,575	0	0	194.03
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)	9,428,859	64,043,401	11,993,200	2,656,884	78,967	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
5/28/2013 9:24 am

Cost Center Description		OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.02	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01	
4.00	00400	EMPLOYEE BENEFITS					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT					7.00	
7.01	00701	OPERATION OF PLANT -OFFSITE					7.01	
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	950,642				7.02	
8.00	00800	LAUNDRY & LINEN SERVICE	12,596	341,511			8.00	
9.00	00900	HOUSEKEEPING	12,794	12,016	1,351,874		9.00	
10.00	01000	DIETARY	8,061	626	12,648	439,818	10.00	
11.00	01100	CAFETERIA	28,817	2,183	45,214	0	11.00	
13.00	01300	NURSING ADMINISTRATION	0	0	0	59,330	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	9,539	4,997	14,967	0	14.00	
15.00	01500	PHARMACY	6,762	0	10,609	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	15,042	0	23,600	0	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	91,484	90,651	143,536	411,986	296,143	30.00
31.00	03100	INTENSIVE CARE UNIT	14,942	5,615	23,444	27,832	57,838	31.00
43.00	04300	NURSERY	4,660	13,625	7,312	0	57,097	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	17,495	37,505	27,449	0	152,131	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,876	1,589	12,357	0	10,059	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	132,055	28,047	207,192	0	156,991	54.00
60.00	06000	LABORATORY	32,835	0	51,517	0	179,982	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	11,542	2,582	18,108	0	0	65.00
66.00	06600	PHYSICAL THERAPY	20,544	24,694	32,233	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,226	0	11,337	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,281	0	5,149	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	22,195	1,106	34,823	0	35,013	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,470	14,671	19,565	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	61,321	27,458	96,211	0	0	90.00
90.01	09001	WOUND CLINIC	4,097	0	6,428	0	0	90.01
91.00	09100	EMERGENCY	55,739	74,146	87,453	0	194,457	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	22,639	0	35,520	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)	616,012	341,511	926,672	439,818	1,358,268	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	326,641	0	412,669	0	59,059	192.00
192.01	19201	PRIVATE DUTY	0	0	0	0	0	192.01
194.00	07950	COMMUNITY RELATIONS	2,778	0	4,358	0	15,418	194.00
194.01	07951	COMMUNITY BENEFITS	5,211	0	8,175	0	35,392	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	3,122	194.03
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)	950,642	341,511	1,351,874	439,818	1,471,259	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
7.01	00701						7.01
7.02	00702						7.02
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	1,137,024					13.00
14.00	01400	0	646,164				14.00
15.00	01500	0	111,209	2,929,386			15.00
16.00	01600	0	500	0	1,752,519		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	546,985	7,339	0	1,289,589	7,355,179	30.00
31.00	03100	106,829	711	0	0	1,121,465	31.00
43.00	04300	105,461	0	0	0	1,128,992	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	184,633	0	261,776	4,556,734	50.00
52.00	05200	18,580	7,126	0	0	291,044	52.00
54.00	05400	0	193,686	0	38,577	9,457,787	54.00
60.00	06000	0	78,644	0	0	4,700,192	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	5,595	0	0	1,148,618	65.00
66.00	06600	0	1,267	0	0	1,698,171	66.00
67.00	06700	0	5,205	0	0	947,401	67.00
68.00	06800	0	80	0	0	244,878	68.00
69.00	06900	0	1,141	0	123,999	1,164,125	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	1,392,456	72.00
73.00	07300	0	0	2,929,386	0	2,929,386	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	9,927	0	2,756	2,384,987	90.00
90.01	09001	0	10,322	0	0	555,819	90.01
91.00	09100	359,169	6,438	0	22,044	4,292,305	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	1,118	0	0	2,479,173	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	7,254	0	0	1,183,551	116.00
118.00		1,137,024	632,195	2,929,386	1,738,741	49,032,263	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	13,163	0	13,778	13,499,344	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	8	0	0	671,965	194.00
194.01	07951	0	742	0	0	686,731	194.01
194.02	07952	0	0	0	0	72,090	194.02
194.03	07953	0	56	0	0	81,008	194.03
200.00						0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,137,024	646,164	2,929,386	1,752,519	64,043,401	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSITE		2.01
4.00	00400	EMPLOYEE BENEFITS		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE		7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS		7.02
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	7,355,179
31.00	03100	INTENSIVE CARE UNIT	0	1,121,465
43.00	04300	NURSERY	0	1,128,992
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,556,734
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	291,044
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,457,787
60.00	06000	LABORATORY	0	4,700,192
60.01	06001	BLOOD LABORATORY	0	0
65.00	06500	RESPIRATORY THERAPY	0	1,148,618
66.00	06600	PHYSICAL THERAPY	0	1,698,171
67.00	06700	OCCUPATIONAL THERAPY	0	947,401
68.00	06800	SPEECH PATHOLOGY	0	244,878
69.00	06900	ELECTROCARDIOLOGY	0	1,164,125
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,392,456
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,929,386
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	2,384,987
90.01	09001	WOUND CLINIC	0	555,819
91.00	09100	EMERGENCY	0	4,292,305
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	2,479,173
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	0	1,183,551
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	49,032,263
NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	13,499,344
192.01	19201	PRIVATE DUTY	0	0
194.00	07950	COMMUNITY RELATIONS	0	671,965
194.01	07951	COMMUNITY BENEFITS	0	686,731
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	72,090
194.03	07953	EMS	0	81,008
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	64,043,401

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	
		1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01 00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
4.00 00400	EMPLOYEE BENEFITS	0	23,468	0	28,966	0
5.00 00500	ADMINISTRATIVE & GENERAL	0	358,276	0	442,204	0
7.00 00700	OPERATION OF PLANT	0	365,149	0	450,690	0
7.01 00701	OPERATION OF PLANT -OFFSITE	0	0	0	0	0
7.02 00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	0
8.00 00800	LAUNDRY & LINEN SERVICE	0	28,767	0	35,506	0
9.00 00900	HOUSEKEEPING	0	29,222	0	36,067	0
10.00 01000	DIETARY	0	18,411	0	22,724	0
11.00 01100	CAFETERIA	0	65,817	0	81,235	0
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	0	21,788	0	26,891	0
15.00 01500	PHARMACY	0	15,444	0	19,061	0
16.00 01600	MEDICAL RECORDS & LIBRARY	0	34,354	0	42,402	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	208,943	0	257,889	0
31.00 03100	INTENSIVE CARE UNIT	0	34,127	0	42,122	0
43.00 04300	NURSERY	0	10,644	0	13,137	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	39,956	0	49,317	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	17,987	0	22,201	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	301,604	0	372,256	0
60.00 06000	LABORATORY	0	74,992	0	92,560	0
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	0	26,360	0	32,535	0
66.00 06600	PHYSICAL THERAPY	0	46,921	0	57,913	0
67.00 06700	OCCUPATIONAL THERAPY	0	16,503	0	20,369	0
68.00 06800	SPEECH PATHOLOGY	0	7,495	0	9,250	0
69.00 06900	ELECTROCARDIOLOGY	0	50,691	0	62,566	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	28,480	0	35,151	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	140,052	0	172,860	0
90.01 09001	WOUND CLINIC	0	9,357	0	11,549	0
91.00 09100	EMERGENCY	0	127,304	0	157,125	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	51,706	0	63,818	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,153,818	0	2,658,364	0
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	116,887	280,936	144,268	101,039
192.01 19201	PRIVATE DUTY	0	0	0	0	0
194.00 07950	COMMUNITY RELATIONS	0	6,344	0	7,830	0
194.01 07951	COMMUNITY BENEFITS	0	11,901	0	14,688	0
194.02 07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.03 07953	EMS	0	0	0	0	0
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	0	2,288,950	280,936	2,825,150	101,039

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

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Cost Center Description		Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
		2A	4.00	5.00	7.00	7.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
4.00	00400	EMPLOYEE BENEFITS	52,434	52,434			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	800,480	7,287	807,767		5.00
7.00	00700	OPERATION OF PLANT	815,839	0	33,511	849,350	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	996	0	996 7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	1,071	11,990	0	0 7.02
8.00	00800	LAUNDRY & LINEN SERVICE	64,273	157	3,523	15,845	0 8.00
9.00	00900	HOUSEKEEPING	65,289	1,161	16,103	16,095	0 9.00
10.00	01000	DIETARY	41,135	301	4,878	10,141	0 10.00
11.00	01100	CAFETERIA	147,052	1,077	16,165	36,251	0 11.00
13.00	01300	NURSING ADMINISTRATION	0	1,209	13,593	0	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	48,679	0	7,304	12,000	0 14.00
15.00	01500	PHARMACY	34,505	938	34,410	8,506	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	76,756	1,445	19,436	18,922	0 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	466,832	3,752	51,933	115,084	0 30.00
31.00	03100	INTENSIVE CARE UNIT	76,249	812	10,411	18,797	0 31.00
43.00	04300	NURSERY	23,781	856	11,635	5,863	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	89,273	2,241	48,016	22,008	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	40,188	151	2,554	9,907	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	673,860	3,642	103,193	166,120	0 54.00
60.00	06000	LABORATORY	167,552	2,169	53,327	41,305	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	58,895	1,021	13,437	14,519	0 65.00
66.00	06600	PHYSICAL THERAPY	104,834	1,537	19,406	25,844	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	36,872	869	11,291	9,090	0 67.00
68.00	06800	SPEECH PATHOLOGY	16,745	226	2,818	4,128	0 68.00
69.00	06900	ELECTROCARDIOLOGY	113,257	660	10,828	27,920	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	63,631	0	16,355	15,686	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	312,912	1,521	24,545	77,139	0 90.00
90.01	09001	WOUND CLINIC	20,906	377	6,544	5,154	0 90.01
91.00	09100	EMERGENCY	284,429	2,979	41,288	70,118	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0				0 92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	115,524	2,170	29,398	28,479	0 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	995	14,836	0	0 116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,812,182	40,624	633,724	774,921	0 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	643,130	10,941	156,321	64,380	996 192.00
192.01	19201	PRIVATE DUTY	0	0	0	0	0 192.01
194.00	07950	COMMUNITY RELATIONS	14,174	217	8,053	3,494	0 194.00
194.01	07951	COMMUNITY BENEFITS	26,589	543	7,778	6,555	0 194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	80	909	0	0 194.02
194.03	07953	EMS	0	29	982	0	0 194.03
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)	5,496,075	52,434	807,767	849,350	996 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151329

Period:
From 01/01/2012
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Cost Center Description		OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.02	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT -OFFSITE					7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	13,061				7.02
8.00	00800	LAUNDRY & LINEN SERVICE	173	83,971			8.00
9.00	00900	HOUSEKEEPING	176	2,955	101,779		9.00
10.00	01000	DIETARY	111	154	952	57,672	10.00
11.00	01100	CAFETERIA	396	537	3,404	0	204,882
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	8,262
14.00	01400	CENTRAL SERVICES & SUPPLY	131	1,229	1,127	0	0
15.00	01500	PHARMACY	93	0	799	0	6,407
16.00	01600	MEDICAL RECORDS & LIBRARY	207	0	1,777	0	15,766
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,257	22,288	10,806	54,022	41,240
31.00	03100	INTENSIVE CARE UNIT	205	1,381	1,765	3,650	8,054
43.00	04300	NURSERY	64	3,350	551	0	7,951
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	240	9,222	2,067	0	21,185
52.00	05200	DELIVERY ROOM & LABOR ROOM	108	391	930	0	1,401
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,814	6,896	15,599	0	21,862
60.00	06000	LABORATORY	451	0	3,879	0	25,064
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	159	635	1,363	0	0
66.00	06600	PHYSICAL THERAPY	282	6,072	2,427	0	0
67.00	06700	OCCUPATIONAL THERAPY	99	0	854	0	0
68.00	06800	SPEECH PATHOLOGY	45	0	388	0	0
69.00	06900	ELECTROCARDIOLOGY	305	272	2,622	0	4,876
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	171	3,607	1,473	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	842	6,751	7,243	0	0
90.01	09001	WOUND CLINIC	56	0	484	0	0
91.00	09100	EMERGENCY	766	18,231	6,584	0	27,079
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	311	0	2,674	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,462	83,971	69,768	57,672	189,147
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,489	0	31,068	0	8,224
192.01	19201	PRIVATE DUTY	0	0	0	0	0
194.00	07950	COMMUNITY RELATIONS	38	0	328	0	2,147
194.01	07951	COMMUNITY BENEFITS	72	0	615	0	4,929
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.03	07953	EMS	0	0	0	0	435
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	13,061	83,971	101,779	57,672	204,882

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet B Part II Date/Time Prepared: 5/28/2013 9:24 am
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT -OFFSITE					7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS					7.02
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	23,064				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	70,470			14.00
15.00	01500	PHARMACY	0	12,128	97,786		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	55	0	134,364	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,095	800	0	98,872	877,981
31.00	03100	INTENSIVE CARE UNIT	2,167	78	0	0	123,569
43.00	04300	NURSERY	2,139	0	0	0	56,190
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	20,135	0	20,070	234,457
52.00	05200	DELIVERY ROOM & LABOR ROOM	377	777	0	0	56,784
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,125	0	2,958	1,017,069
60.00	06000	LABORATORY	0	8,576	0	0	302,323
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	610	0	0	90,639
66.00	06600	PHYSICAL THERAPY	0	138	0	0	160,540
67.00	06700	OCCUPATIONAL THERAPY	0	568	0	0	59,643
68.00	06800	SPEECH PATHOLOGY	0	9	0	0	24,359
69.00	06900	ELECTROCARDIOLOGY	0	124	0	9,507	170,371
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	100,923
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	97,786	0	97,786
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	1,083	0	211	432,247
90.01	09001	WOUND CLINIC	0	1,126	0	0	34,647
91.00	09100	EMERGENCY	7,286	702	0	1,690	461,152
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	122	0	0	178,678
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	791	0	0	16,622
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,064	68,947	97,786	133,308	4,495,980
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,435	0	1,056	922,040
192.01	19201	PRIVATE DUTY	0	0	0	0	0
194.00	07950	COMMUNITY RELATIONS	0	1	0	0	28,452
194.01	07951	COMMUNITY BENEFITS	0	81	0	0	47,162
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	989
194.03	07953	EMS	0	6	0	0	1,452
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	23,064	70,470	97,786	134,364	5,496,075

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet B Part II Date/Time Prepared: 5/28/2013 9:24 am
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSITE		2.01
4.00	00400	EMPLOYEE BENEFITS		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE		7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS		7.02
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	877,981
31.00	03100	INTENSIVE CARE UNIT	0	123,569
43.00	04300	NURSERY	0	56,190
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	234,457
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	56,784
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,017,069
60.00	06000	LABORATORY	0	302,323
60.01	06001	BLOOD LABORATORY	0	0
65.00	06500	RESPIRATORY THERAPY	0	90,639
66.00	06600	PHYSICAL THERAPY	0	160,540
67.00	06700	OCCUPATIONAL THERAPY	0	59,643
68.00	06800	SPEECH PATHOLOGY	0	24,359
69.00	06900	ELECTROCARDIOLOGY	0	170,371
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	100,923
73.00	07300	DRUGS CHARGED TO PATIENTS	0	97,786
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	432,247
90.01	09001	WOUND CLINIC	0	34,647
91.00	09100	EMERGENCY	0	461,152
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	178,678
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	0	16,622
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,495,980
NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	922,040
192.01	19201	PRIVATE DUTY	0	0
194.00	07950	COMMUNITY RELATIONS	0	28,452
194.01	07951	COMMUNITY BENEFITS	0	47,162
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	989
194.03	07953	EMS	0	1,452
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	5,496,075

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151329

Period:
From 01/01/2012
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Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS (GROSS SALARIES)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSITE (SQUARE FEET)		
		1.00	1.01	2.00	2.01		
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	151,178				1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	0	41,553			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			151,178		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSITE			0	41,553	2.01
4.00	00400	EMPLOYEE BENEFITS	1,550	0	1,550	0	27,779,975
5.00	00500	ADMINISTRATIVE & GENERAL	23,663	0	23,663	0	3,861,427
7.00	00700	OPERATION OF PLANT	24,117	0	24,117	0	0
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	0	0	0
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	567,385
8.00	00800	LAUNDRY & LINEN SERVICE	1,900	0	1,900	0	83,395
9.00	00900	HOUSEKEEPING	1,930	0	1,930	0	615,333
10.00	01000	DIETARY	1,216	0	1,216	0	159,664
11.00	01100	CAFETERIA	4,347	0	4,347	0	570,638
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	640,563
14.00	01400	CENTRAL SERVICES & SUPPLY	1,439	0	1,439	0	0
15.00	01500	PHARMACY	1,020	0	1,020	0	497,333
16.00	01600	MEDICAL RECORDS & LIBRARY	2,269	0	2,269	0	765,681
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,800	0	13,800	0	1,988,286
31.00	03100	INTENSIVE CARE UNIT	2,254	0	2,254	0	430,507
43.00	04300	NURSERY	703	0	703	0	453,863
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,639	0	2,639	0	1,187,417
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,188	0	1,188	0	79,953
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,920	0	19,920	0	1,930,068
60.00	06000	LABORATORY	4,953	0	4,953	0	1,149,600
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,741	0	1,741	0	541,173
66.00	06600	PHYSICAL THERAPY	3,099	0	3,099	0	814,573
67.00	06700	OCCUPATIONAL THERAPY	1,090	0	1,090	0	460,700
68.00	06800	SPEECH PATHOLOGY	495	0	495	0	120,009
69.00	06900	ELECTROCARDIOLOGY	3,348	0	3,348	0	349,530
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,881	0	1,881	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	9,250	0	9,250	0	805,918
90.01	09001	WOUND CLINIC	618	0	618	0	199,808
91.00	09100	EMERGENCY	8,408	0	8,408	0	1,578,544
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,415	0	3,415	0	1,150,057
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	0	0	0	0	527,223
118.00		SUBTOTALS (SUM OF LINES 1-117)	142,253	0	142,253	0	21,528,648
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,720	41,553	7,720	41,553	5,790,609
192.01	19201	PRIVATE DUTY	0	0	0	0	0
194.00	07950	COMMUNITY RELATIONS	419	0	419	0	115,034
194.01	07951	COMMUNITY BENEFITS	786	0	786	0	287,737
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	42,649
194.03	07953	EMS	0	0	0	0	15,298
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	2,288,950	280,936	2,825,150	101,039	9,428,859
203.00		Unit cost multiplier (Wkst. B, Part I)	15.140761	6.760908	18.687574	2.431569	0.339412
204.00		Cost to be allocated (per Wkst. B, Part II)					52,434
205.00		Unit cost multiplier (Wkst. B, Part II)					0.001887

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151329

Period:
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Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT -OFFSITE					7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS					7.02
8.00	00800	LAUNDRY & LINEN SERVICE	397,042				8.00
9.00	00900	HOUSEKEEPING	13,970	129,973			9.00
10.00	01000	DIETARY	728	1,216	19,595		10.00
11.00	01100	CAFETERIA	2,538	4,347	0	407,179	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	16,420	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,809	1,439	0	0	14.00
15.00	01500	PHARMACY	0	1,020	0	12,733	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,269	0	31,334	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	105,392	13,800	18,355	81,959	30.00
31.00	03100	INTENSIVE CARE UNIT	6,528	2,254	1,240	16,007	31.00
43.00	04300	NURSERY	15,841	703	0	15,802	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	43,604	2,639	0	42,103	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,847	1,188	0	2,784	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,607	19,920	0	43,448	54.00
60.00	06000	LABORATORY	0	4,953	0	49,811	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	3,002	1,741	0	0	65.00
66.00	06600	PHYSICAL THERAPY	28,709	3,099	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,090	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	495	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,286	3,348	0	9,690	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	17,056	1,881	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	31,923	9,250	0	0	90.00
90.01	09001	WOUND CLINIC	0	618	0	0	90.01
91.00	09100	EMERGENCY	86,202	8,408	0	53,817	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	3,415	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	397,042	89,093	19,595	375,908	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	39,675	0	16,345	192.00
192.01	19201	PRIVATE DUTY	0	0	0	0	192.01
194.00	07950	COMMUNITY RELATIONS	0	419	0	4,267	194.00
194.01	07951	COMMUNITY BENEFITS	0	786	0	9,795	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	864	194.03
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)	341,511	1,351,874	439,818	1,471,259	1,137,024
203.00		Unit cost multiplier (Wkst. B, Part I)	0.860138	10.401191	22.445420	3.613298	6.673890
204.00		Cost to be allocated (per Wkst. B, Part II)	83,971	101,779	57,672	204,882	23,064
205.00		Unit cost multiplier (Wkst. B, Part II)	0.211491	0.783078	2.943200	0.503174	0.135377

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151329

Period:
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Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (100% PHARMACY)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT			2.01
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT -OFFSITE			7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,880,349		14.00
15.00	01500	PHARMACY	1,356,254	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,102	0	636
16.00	01600	MEDICAL RECORDS & LIBRARY	6,102	0	636
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	89,508	0	468
31.00	03100	INTENSIVE CARE UNIT	8,671	0	0
43.00	04300	NURSERY	0	0	0
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,251,708	0	95
52.00	05200	DELIVERY ROOM & LABOR ROOM	86,910	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,362,087	0	14
60.00	06000	LABORATORY	959,114	0	0
60.01	06001	BLOOD LABORATORY	0	0	0
65.00	06500	RESPIRATORY THERAPY	68,239	0	0
66.00	06600	PHYSICAL THERAPY	15,455	0	0
67.00	06700	OCCUPATIONAL THERAPY	63,482	0	0
68.00	06800	SPEECH PATHOLOGY	971	0	0
69.00	06900	ELECTROCARDIOLOGY	13,912	0	45
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	121,068	0	1
90.01	09001	WOUND CLINIC	125,883	0	0
91.00	09100	EMERGENCY	78,520	0	8
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	13,639	0	0
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			
116.00	11600	HOSPICE	88,466	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,709,989	100	631
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	160,527	0	5
192.01	19201	PRIVATE DUTY	0	0	0
194.00	07950	COMMUNITY RELATIONS	99	0	0
194.01	07951	COMMUNITY BENEFITS	9,049	0	0
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0
194.03	07953	EMS	685	0	0
200.00		Cross Foot Adjustments			
201.00		Negative Cost Centers			
202.00		Cost to be allocated (per Wkst. B, Part I)	646,164	2,929,386	1,752,519
203.00		Unit cost multiplier (Wkst. B, Part I)	0.081997	29,293.860000	2,755.533019
204.00		Cost to be allocated (per Wkst. B, Part II)	70,470	97,786	134,364
205.00		Unit cost multiplier (Wkst. B, Part II)	0.008942	977.860000	211.264151

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII		Hospital		Cost		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Diallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	7,355,179		7,355,179	0	0	6,825,870	30.00
31.00	03100	INTENSIVE CARE UNIT	1,121,465		1,121,465	0	0	965,255	31.00
43.00	04300	NURSERY	1,128,992		1,128,992	0	0	1,892,389	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	4,556,734		4,556,734	0	0	3,240,472	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	291,044		291,044	0	0	782,265	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,457,787		9,457,787	0	0	1,321,291	54.00
60.00	06000	LABORATORY	4,700,192		4,700,192	0	0	2,869,438	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,148,618	0	1,148,618	0	0	1,920,061	65.00
66.00	06600	PHYSICAL THERAPY	1,698,171	0	1,698,171	0	0	240,310	66.00
67.00	06700	OCCUPATIONAL THERAPY	947,401	0	947,401	0	0	97,674	67.00
68.00	06800	SPEECH PATHOLOGY	244,878	0	244,878	0	0	62,430	68.00
69.00	06900	ELECTROCARDIOLOGY	1,164,125		1,164,125	0	0	469,512	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,392,456		1,392,456	0	0	1,029,590	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,929,386		2,929,386	0	0	3,639,803	73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	2,384,987		2,384,987	0	0	202,536	90.00
90.01	09001	WOUND CLINIC	555,819		555,819	0	0	2,713	90.01
91.00	09100	EMERGENCY	4,292,305		4,292,305	0	0	365,470	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	961,616		961,616	0	0	36,394	92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	2,479,173		2,479,173		0	0	101.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
116.00	11600	HOSPICE	1,183,551		1,183,551	0	0	0	116.00
200.00		Subtotal (see instructions)	49,993,879	0	49,993,879	0	0	25,963,473	200.00
201.00		Less Observation Beds	961,616		961,616		0		201.00
202.00		Total (see instructions)	49,032,263	0	49,032,263	0	0	25,963,473	202.00
Charges									
Cost Center Description	Outpatient		Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio			
	7.00	8.00					9.00	10.00	11.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS						6,825,870	30.00
31.00	03100	INTENSIVE CARE UNIT						965,255	31.00
43.00	04300	NURSERY						1,892,389	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	11,842,727	15,083,199	0.302107	0.000000	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	89,698	871,963	0.333780	0.000000	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,898,685	36,219,976	0.261121	0.000000	0.000000		54.00
60.00	06000	LABORATORY	16,148,924	19,018,362	0.247140	0.000000	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	500,092	2,420,153	0.474606	0.000000	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	2,471,178	2,711,488	0.626287	0.000000	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,052,443	1,150,117	0.823743	0.000000	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	123,299	185,729	1.318469	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	2,895,147	3,364,659	0.345986	0.000000	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	739,633	1,769,223	0.787044	0.000000	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,104,645	7,744,448	0.378256	0.000000	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	4,119,193	4,321,729	0.551859	0.000000	0.000000		90.00
90.01	09001	WOUND CLINIC	962,234	964,947	0.576010	0.000000	0.000000		90.01
91.00	09100	EMERGENCY	6,421,242	6,786,712	0.632457	0.000000	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,361,074	1,397,468	0.688113	0.000000	0.000000		92.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

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Part I
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Cost Center Description	Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	Cost		
	Outpatient	Total (col. 6 + col. 7)						
	7.00	8.00				9.00	10.00	11.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,860,930	1,860,930				101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,992,285	1,992,285				116.00
200.00		Subtotal (see instructions)	91,583,429	117,546,902				200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	91,583,429	117,546,902				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet C
Part I
Date/Time Prepared:
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			Title XIX		Hospital		Cost		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Diallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	7,355,179		7,355,179	0	0	6,825,870	30.00
31.00	03100	INTENSIVE CARE UNIT	1,121,465		1,121,465	0	0	965,255	31.00
43.00	04300	NURSERY	1,128,992		1,128,992	0	0	1,892,389	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	4,556,734		4,556,734	0	0	3,240,472	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	291,044		291,044	0	0	782,265	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,457,787		9,457,787	0	0	1,321,291	54.00
60.00	06000	LABORATORY	4,700,192		4,700,192	0	0	2,869,438	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,148,618	0	1,148,618	0	0	1,920,061	65.00
66.00	06600	PHYSICAL THERAPY	1,698,171	0	1,698,171	0	0	240,310	66.00
67.00	06700	OCCUPATIONAL THERAPY	947,401	0	947,401	0	0	97,674	67.00
68.00	06800	SPEECH PATHOLOGY	244,878	0	244,878	0	0	62,430	68.00
69.00	06900	ELECTROCARDIOLOGY	1,164,125		1,164,125	0	0	469,512	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,392,456		1,392,456	0	0	1,029,590	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,929,386		2,929,386	0	0	3,639,803	73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	2,384,987		2,384,987	0	0	202,536	90.00
90.01	09001	WOUND CLINIC	555,819		555,819	0	0	2,713	90.01
91.00	09100	EMERGENCY	4,292,305		4,292,305	0	0	365,470	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	961,616		961,616	0	0	36,394	92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	2,479,173		2,479,173		0	0	101.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
116.00	11600	HOSPICE	1,183,551		1,183,551	0	0	0	116.00
200.00		Subtotal (see instructions)	49,993,879	0	49,993,879	0	0	25,963,473	200.00
201.00		Less Observation Beds	961,616		961,616		0		201.00
202.00		Total (see instructions)	49,032,263	0	49,032,263	0	0	25,963,473	202.00
Charges									
Cost Center Description	Outpatient		Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio			
	7.00	8.00					9.00	10.00	11.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS						6,825,870	30.00
31.00	03100	INTENSIVE CARE UNIT						965,255	31.00
43.00	04300	NURSERY						1,892,389	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	11,842,727	15,083,199	0.302107	0.000000	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	89,698	871,963	0.333780	0.000000	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,898,685	36,219,976	0.261121	0.000000	0.000000		54.00
60.00	06000	LABORATORY	16,148,924	19,018,362	0.247140	0.000000	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	500,092	2,420,153	0.474606	0.000000	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	2,471,178	2,711,488	0.626287	0.000000	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,052,443	1,150,117	0.823743	0.000000	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	123,299	185,729	1.318469	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	2,895,147	3,364,659	0.345986	0.000000	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	739,633	1,769,223	0.787044	0.000000	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,104,645	7,744,448	0.378256	0.000000	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	4,119,193	4,321,729	0.551859	0.000000	0.000000		90.00
90.01	09001	WOUND CLINIC	962,234	964,947	0.576010	0.000000	0.000000		90.01
91.00	09100	EMERGENCY	6,421,242	6,786,712	0.632457	0.000000	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,361,074	1,397,468	0.688113	0.000000	0.000000		92.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet C
Part I
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Cost Center Description	Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	Hospital	Cost
	Outpatient	Total (col. 6 + col. 7)					
	7.00	8.00					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	1,860,930	1,860,930				101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	1,992,285	1,992,285				116.00
200.00	Subtotal (see instructions)	91,583,429	117,546,902				200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	91,583,429	117,546,902				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/28/2013 9:24 am
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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	234,457	15,083,199	0.015544	1,020,589	15,864	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	56,784	871,963	0.065122	6,943	452	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,017,069	36,219,976	0.028080	604,827	16,984	54.00
60.00	06000 LABORATORY	302,323	19,018,362	0.015896	1,429,870	22,729	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	90,639	2,420,153	0.037452	1,165,374	43,646	65.00
66.00	06600 PHYSICAL THERAPY	160,540	2,711,488	0.059207	143,654	8,505	66.00
67.00	06700 OCCUPATIONAL THERAPY	59,643	1,150,117	0.051858	57,600	2,987	67.00
68.00	06800 SPEECH PATHOLOGY	24,359	185,729	0.131153	50,128	6,574	68.00
69.00	06900 ELECTROCARDIOLOGY	170,371	3,364,659	0.050635	288,314	14,599	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	100,923	1,769,223	0.057044	536,969	30,631	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	97,786	7,744,448	0.012627	1,827,498	23,076	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	432,247	4,321,729	0.100017	118,722	11,874	90.00
90.01	09001 WOUND CLINIC	34,647	964,947	0.035906	2,007	72	90.01
91.00	09100 EMERGENCY	461,152	6,786,712	0.067949	5,117	348	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,397,468	0.000000	0	0	92.00
200.00	Total (lines 50-199)	3,242,940	104,010,173		7,257,612	198,341	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet D
Part IV
Date/Time Prepared:
5/28/2013 9:24 am

Cost Center Description			Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	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	0	0	0	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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
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							
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0 90.01
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
200.00		Total (lines 50-199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

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	15,083,199	0.000000	0.000000	1,020,589	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	871,963	0.000000	0.000000	6,943	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	36,219,976	0.000000	0.000000	604,827	54.00
60.00	06000	LABORATORY	0	19,018,362	0.000000	0.000000	1,429,870	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	2,420,153	0.000000	0.000000	1,165,374	65.00
66.00	06600	PHYSICAL THERAPY	0	2,711,488	0.000000	0.000000	143,654	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,150,117	0.000000	0.000000	57,600	67.00
68.00	06800	SPEECH PATHOLOGY	0	185,729	0.000000	0.000000	50,128	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,364,659	0.000000	0.000000	288,314	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,769,223	0.000000	0.000000	536,969	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,744,448	0.000000	0.000000	1,827,498	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	4,321,729	0.000000	0.000000	118,722	90.00
90.01	09001	WOUND CLINIC	0	964,947	0.000000	0.000000	2,007	90.01
91.00	09100	EMERGENCY	0	6,786,712	0.000000	0.000000	5,117	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,397,468	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	104,010,173			7,257,612	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet D
Part IV
Date/Time Prepared:
5/28/2013 9:24 am

Cost Center Description			Title XVIII			Hospital		Cost	
			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 3/1	Outpatient Program Charges on/after 3/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 3/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 3/1		
			11.00	12.00	12.01	13.00	13.01		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/28/2013 9:24 am
		Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	
		PPS Reimbursed Services (see inst.) before 3/1	PPS Reimbursed Services (see inst.) on/after 3/1	Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	1.00	2.00	2.01	3.00	4.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.302107	0	0	2,591,727	3	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.333780	0	0	5,186	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261121	0	0	12,550,337	4,114	54.00
60.00	06000	LABORATORY	0.247140	0	0	3,532,797	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.474606	0	0	203,444	0	65.00
66.00	06600	PHYSICAL THERAPY	0.626287	0	0	619,539	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.823743	0	0	218,103	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.318469	0	0	16,322	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.345986	0	0	1,062,518	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.787044	0	0	249,140	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.378256	0	0	1,279,518	473	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.551859	0	0	1,217,520	711	90.00
90.01	09001	WOUND CLINIC	0.576010	0	0	438,285	123	90.01
91.00	09100	EMERGENCY	0.632457	0	0	1,787,801	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.688113	0	0	503,279	0	92.00
200.00		Subtotal (see instructions)		0	0	26,275,516	5,424	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	26,275,516	5,424	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/28/2013 9:24 am
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Cost Center Description	Title XVIII				Hospital	Cost	
	Costs						
	PPS Services (see inst.) before 3/1	PPS Services (see inst.) on/after 3/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	5.00	5.01	6.00	7.00			
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	782,979	1	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,731	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,277,157	1,074	54.00
60.00	06000	LABORATORY	0	0	873,095	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	96,556	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	388,009	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	179,661	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	21,520	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	367,616	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	196,084	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	483,985	179	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	671,899	392	90.00
90.01	09001	WOUND CLINIC	0	0	252,457	71	90.01
91.00	09100	EMERGENCY	0	0	1,130,707	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	346,313	0	92.00
200.00		Subtotal (see instructions)	0	0	9,069,769	1,717	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	9,069,769	1,717	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/28/2013 9:24 am
Cost Center Description		Title XVIII	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)		5,706	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,706	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)		4,960	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,238	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			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		7,355,179	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		7,355,179	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		8,718,259	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		8,718,259	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.843652	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,757.71	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		7,355,179	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)		1,289.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,884,849	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)		2,884,849	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/28/2013 9:24 am		
Cost Center Description			Title XVIII		Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,121,465	519	2,160.82	313	676,337	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)					2,862,100	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,423,286	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)					746	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,289.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					961,616	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet D-1

Date/Time Prepared:
5/28/2013 9:24 am

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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XIX		Hospital
				Date/Time Prepared: 5/28/2013 9:24 am
Cost Center Description				Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,706	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,706	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)		4,960	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)		316	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)		925	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		7,355,179	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		7,355,179	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		8,718,259	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		8,718,259	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.843652	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,757.71	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		7,355,179	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)		1,289.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		407,333	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)		407,333	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/28/2013 9:24 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)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	1,128,992	925	1,220.53	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,121,465	519	2,160.82	7	15,126	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)					190,387	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					612,846	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)					746	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,289.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					961,616	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet D-1
Date/Time Prepared:
5/28/2013 9:24 am

Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
				Total Observation Bed Cost (from line 89)	Cost		
	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	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/28/2013 9:24 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		3,125,997	30.00
31.00	03100	INTENSIVE CARE UNIT		582,157	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.302107	1,020,589	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.333780	6,943	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261121	604,827	54.00
60.00	06000	LABORATORY	0.247140	1,429,870	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.474606	1,165,374	65.00
66.00	06600	PHYSICAL THERAPY	0.626287	143,654	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.823743	57,600	67.00
68.00	06800	SPEECH PATHOLOGY	1.318469	50,128	68.00
69.00	06900	ELECTROCARDIOLOGY	0.345986	288,314	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.787044	536,969	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.378256	1,827,498	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.551859	118,722	90.00
90.01	09001	WOUND CLINIC	0.576010	2,007	90.01
91.00	09100	EMERGENCY	0.632457	5,117	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.688113	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		7,257,612	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		7,257,612	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/28/2013 9:24 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		463,814	30.00
31.00	03100	INTENSIVE CARE UNIT		30,709	31.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.302107	39,603	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.333780	34,509	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261121	61,653	54.00
60.00	06000	LABORATORY	0.247140	155,720	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.474606	54,885	65.00
66.00	06600	PHYSICAL THERAPY	0.626287	2,982	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.823743	1,766	67.00
68.00	06800	SPEECH PATHOLOGY	1.318469	10,839	68.00
69.00	06900	ELECTROCARDIOLOGY	0.345986	17,114	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.787044	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.378256	158,991	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.551859	3,132	90.00
90.01	09001	WOUND CLINIC	0.576010	0	90.01
91.00	09100	EMERGENCY	0.632457	1,375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.688113	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		542,569	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		542,569	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/28/2013 9:24 am
		Title XVIII	Hospital	Cost
			before 3/1	on/after 3/1
			1.00	1.01
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		9,071,486	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		9,071,486	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		9,162,201	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		101,209	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		4,507,455	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		4,553,537	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		4,553,537	30.00
31.00	Primary payer payments		1,901	31.00
32.00	Subtotal (line 30 minus line 31)		4,551,636	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)		173,666	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		173,666	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		86,455	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		4,725,302	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	AB Re-billing demo amount (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		4,725,302	40.00
41.00	Interim payments		5,274,695	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)		-549,393	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet E-1
Part I
Date/Time Prepared:
5/28/2013 9:24 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		4,838,564		4,850,587	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		10/31/2012	421,800		0	3.02	
3.03			73,788		424,108	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)		495,588		424,108	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)		5,334,152		5,274,695	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		557,791		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		549,393	6.02	
7.00	Total Medicare program liability (see instructions)		5,891,943		4,725,302	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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet E-1 Part II Date/Time Prepared: 5/28/2013 9:24 am
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			1,797 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			2,551 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			586 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			5,479 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			117,546,902 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			1,814,229 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			1,084,507 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			847,620 8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			729,165 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			118,455 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part V Date/Time Prepared: 5/28/2013 9:24 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services		6,423,286	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		6,423,286	4.00
5.00	Primary payer payments		5,695	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		6,481,824	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		6,481,824	19.00
20.00	Deductibles (exclude professional component)		623,722	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		5,858,102	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		5,858,102	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		33,841	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		33,841	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		17,545	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		5,891,943	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		5,891,943	30.00
31.00	Interim payments		5,334,152	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)		557,791	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2013 9:24 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		612,846		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		612,846	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		612,846	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		542,569	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		542,569	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		542,569	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		70,277	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		612,846	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		612,846	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		70,277	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		612,846	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		612,846	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		612,846	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		612,846	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		612,846	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

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

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet G

Date/Time Prepared:
5/28/2013 9:24 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	5,296,991	0	0	0	1.00
2.00	Temporary investments	20,068	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	12,103,855	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,552,348	0	0	0	6.00
7.00	Inventory	2,918,830	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,198,232	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	16,985,628	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,371,158	0	0	0	12.00
13.00	Land improvements	366,434	0	0	0	13.00
14.00	Accumulated depreciation	-359,855	0	0	0	14.00
15.00	Buildings	70,492,484	0	0	0	15.00
16.00	Accumulated depreciation	-29,404,718	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	6,410,956	0	0	0	19.00
20.00	Accumulated depreciation	-4,102,947	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	31,079,302	0	0	0	23.00
24.00	Accumulated depreciation	-20,851,472	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)	56,001,342	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	53,144,288	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	376,959	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	53,521,247	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	126,508,217	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,438,909	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,516,508	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,198,232	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	2,484,100	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,637,749	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	31,434,572	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,311,447	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	34,746,019	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	46,383,768	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	80,124,449				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	80,124,449	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	126,508,217	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet G-1

Date/Time Prepared:
5/28/2013 9:24 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		67,142,319		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		10,166,190			2.00
3.00	Total (sum of line 1 and line 2)		77,308,509		0	3.00
4.00	UNREALIZED GAIN ON INVESTMENTS	2,738,693		0		4.00
5.00	CONTRIBUTIONS	77,247		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)		2,815,940		0	10.00
11.00	Subtotal (line 3 plus line 10)		80,124,449		0	11.00
12.00	Deductions (debit adjustments) (specify)	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)		80,124,449		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	UNREALIZED GAIN ON INVESTMENTS		0			4.00
5.00	CONTRIBUTIONS		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/28/2013 9:24 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	8,718,259		8,718,259	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)	8,718,259		8,718,259	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	965,255		965,255	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)	965,255		965,255	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	9,683,514		9,683,514	17.00
18.00	Ancillary services	16,075,473	82,690,509	98,765,982	18.00
19.00	Outpatient services	205,249	5,081,427	5,286,676	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		1,860,930	1,860,930	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,992,285	1,992,285	26.00
27.00	PROFESSIONAL FEES	267,484	5,412,446	5,679,930	27.00
27.01	PHYSICIAN OFFICES	0	11,120,300	11,120,300	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	26,231,720	108,157,897	134,389,617	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		68,016,843		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		68,016,843		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151329

Period:
From 01/01/2012
To 12/31/2012

Worksheet G-3

Date/Time Prepared:
5/28/2013 9:24 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	134,389,617	1.00
2.00	Less contractual allowances and discounts on patients' accounts	53,604,394	2.00
3.00	Net patient revenues (line 1 minus line 2)	80,785,223	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	68,016,843	4.00
5.00	Net income from service to patients (line 3 minus line 4)	12,768,380	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	60,398	6.00
7.00	Income from investments	3,346,698	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	490,277	24.00
24.01	UNREALIZED GAIN ON DERIVATIVE	53,154	24.01
25.00	Total other income (sum of lines 6-24)	3,950,527	25.00
26.00	Total (line 5 plus line 25)	16,718,907	26.00
27.00	BAD DEBT EXPENSE	6,533,475	27.00
27.01	LOSS ON DISPOSAL OF PROPERTY	19,242	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	6,552,717	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	10,166,190	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151329

Period: From 01/01/2012

Worksheet H

HHA CCN: 157143

To 12/31/2012

Date/Time Prepared: 5/28/2013 9:24 am

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	309,227	0	0	0	238,403	547,630	5.00
HHA REIMBURSABLE SERVICES							
6.00	441,440	0	0	0	0	441,440	6.00
7.00	208,487	0	0	0	0	208,487	7.00
8.00	79,746	0	0	0	0	79,746	8.00
9.00	3,051	0	0	0	0	3,051	9.00
10.00	10,243	0	0	0	0	10,243	10.00
11.00	82,802	0	0	0	0	82,802	11.00
12.00	0	0	0	0	0	0	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	15,061	0	0	0	0	15,061	22.00
23.00	0	0	0	0	0	0	23.00
24.00	1,150,057	0	0	0	238,403	1,388,460	24.00
	Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	0	547,630	0	547,630			5.00
HHA REIMBURSABLE SERVICES							
6.00	0	441,440	0	441,440			6.00
7.00	0	208,487	0	208,487			7.00
8.00	0	79,746	0	79,746			8.00
9.00	0	3,051	0	3,051			9.00
10.00	0	10,243	0	10,243			10.00
11.00	0	82,802	0	82,802			11.00
12.00	0	0	0	0			12.00
13.00	0	0	0	0			13.00
14.00	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	15,061	0	15,061			22.00
23.00	0	0	0	0			23.00
24.00	0	1,388,460	0	1,388,460			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: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet H-1 Part I Date/Time Prepared: 5/28/2013 9:24 am
		HHA CCN: 157143	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
		1.00	2.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0	0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	547,630	0	0	0	547,630	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	441,440	0	0	0	441,440	6.00
7.00	Physical Therapy	208,487	0	0	0	208,487	7.00
8.00	Occupational Therapy	79,746	0	0	0	79,746	8.00
9.00	Speech Pathology	3,051	0	0	0	3,051	9.00
10.00	Medical Social Services	10,243	0	0	0	10,243	10.00
11.00	Home Health Aide	82,802	0	0	0	82,802	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	15,061	0	0	0	15,061	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,388,460	0	0	0	1,388,460	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	547,630					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	287,509	728,949				6.00
7.00	Physical Therapy	135,787	344,274				7.00
8.00	Occupational Therapy	51,938	131,684				8.00
9.00	Speech Pathology	1,987	5,038				9.00
10.00	Medical Social Services	6,671	16,914				10.00
11.00	Home Health Aide	53,929	136,731				11.00
12.00	Supplies (see instructions)	0	0				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	9,809	24,870				22.00
23.00	All Others (specify)	0	0				23.00
24.00	Total (sum of lines 1-23)		1,388,460				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151329
HHA CCN: 157143

Period:
From 01/01/2012
To 12/31/2012

Worksheet H-1
Part II
Date/Time Prepared:
5/28/2013 9:24 am
PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-547,630	840,830
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	441,440
7.00	Physical Therapy	0	0	0	0	0	208,487
8.00	Occupational Therapy	0	0	0	0	0	79,746
9.00	Speech Pathology	0	0	0	0	0	3,051
10.00	Medical Social Services	0	0	0	0	0	10,243
11.00	Home Health Aide	0	0	0	0	0	82,802
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	15,061
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-547,630	840,830
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		547,630
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.651297

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151329

Period: From 01/01/2012

Worksheet H-2

HHA CCN: 157143

To 12/31/2012

Part I
Date/Time Prepared:
5/28/2013 9:24 am

Home Health Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS					EMPLOYEE BENEFITS	
		HHA Trial Balance (1)	NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSITE		
			1.00	1.01	2.00	2.01		
1.00	Administrative and General	0	51,706	0	63,818	0	390,343	1.00
2.00	Skilled Nursing Care	728,949	0	0	0	0	0	2.00
3.00	Physical Therapy	344,274	0	0	0	0	0	3.00
4.00	Occupational Therapy	131,684	0	0	0	0	0	4.00
5.00	Speech Pathology	5,038	0	0	0	0	0	5.00
6.00	Medical Social Services	16,914	0	0	0	0	0	6.00
7.00	Home Health Aide	136,731	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	24,870	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	1,388,460	51,706	0	63,818	0	390,343	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	
		4A	5.00	7.00	7.01	7.02	8.00	
1.00	Administrative and General	505,867	116,560	89,086	0	22,639	0	1.00
2.00	Skilled Nursing Care	728,949	167,962	0	0	0	0	2.00
3.00	Physical Therapy	344,274	79,326	0	0	0	0	3.00
4.00	Occupational Therapy	131,684	30,342	0	0	0	0	4.00
5.00	Speech Pathology	5,038	1,161	0	0	0	0	5.00
6.00	Medical Social Services	16,914	3,897	0	0	0	0	6.00
7.00	Home Health Aide	136,731	31,505	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	24,870	5,730	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	1,894,327	436,483	89,086	0	22,639	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.	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: 151329		Period: From 01/01/2012 To 12/31/2012		Worksheet H-2 Part I Date/Time Prepared: 5/28/2013 9:24 am		
		HHA CCN: 157143		Home Health Agency I		PPS		
Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	35,520	0	0	0	1,118	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	35,520	0	0	0	1,118	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part I)	Total HHA Costs	
		16.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	770,790	0	770,790			1.00
2.00	Skilled Nursing Care	0	896,911	0	896,911	404,669	1,301,580	2.00
3.00	Physical Therapy	0	423,600	0	423,600	191,120	614,720	3.00
4.00	Occupational Therapy	0	162,026	0	162,026	73,103	235,129	4.00
5.00	Speech Pathology	0	6,199	0	6,199	2,797	8,996	5.00
6.00	Medical Social Services	0	20,811	0	20,811	9,390	30,201	6.00
7.00	Home Health Aide	0	168,236	0	168,236	75,905	244,141	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	30,600	0	30,600	13,806	44,406	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	2,479,173	0	2,479,173	770,790	2,479,173	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.					0.451181		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: 151329
HHA CCN: 157143

Period:
From 01/01/2012
To 12/31/2012

Worksheet H-2
Part II
Date/Time Prepared:
5/28/2013 9:24 am
PPS

Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
		NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSITE (SQUARE FEET)			
		1.00	1.01	2.00	2.01			
1.00	Administrative and General	3,415	0	3,415	0	1,150,057	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	3,415	0	3,415	0	1,150,057	0	20.00
21.00	Total cost to be allocated	51,706	0	63,818	0	390,343	0	21.00
22.00	Unit cost multiplier	15.140849	0.000000	18.687555	0.000000	0.339412	0	22.00
Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5.00	7.00	7.01	7.02	8.00	9.00	
1.00	Administrative and General	505,867	3,415	0	3,415	0	3,415	1.00
2.00	Skilled Nursing Care	728,949	0	0	0	0	0	2.00
3.00	Physical Therapy	344,274	0	0	0	0	0	3.00
4.00	Occupational Therapy	131,684	0	0	0	0	0	4.00
5.00	Speech Pathology	5,038	0	0	0	0	0	5.00
6.00	Medical Social Services	16,914	0	0	0	0	0	6.00
7.00	Home Health Aide	136,731	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	24,870	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)	1,894,327	3,415	0	3,415	0	3,415	20.00
21.00	Total cost to be allocated	436,483	89,086	0	22,639	0	35,520	21.00
22.00	Unit cost multiplier	0.230416	26.086676	0.000000	6.629283	0.000000	10.401171	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151329
HHA CCN: 157143

Period:
From 01/01/2012
To 12/31/2012

Worksheet H-2
Part II
Date/Time Prepared:
5/28/2013 9:24 am
PPS

Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (100% PHARMACY)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
	10.00	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	0	0	0	13,639	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	0	13,639	0	0	20.00
21.00 Total cost to be allocated	0	0	0	1,118	0	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.081971	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet H-3 Part I Date/Time Prepared: 5/28/2013 9:24 am
		HHA CCN: 157143	Title XVIII	Home Health Agency I

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

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	1,301,580		1,301,580	6,044	215.35	1.00
2.00	Physical Therapy	3.00	614,720	0	614,720	2,333	263.49	2.00
3.00	Occupational Therapy	4.00	235,129	0	235,129	708	332.10	3.00
4.00	Speech Pathology	5.00	8,996	0	8,996	63	142.79	4.00
5.00	Medical Social Services	6.00	30,201		30,201	16	1,887.56	5.00
6.00	Home Health Aide	7.00	244,141		244,141	1,216	200.77	6.00
7.00	Total (sum of lines 1-6)		2,434,767	0	2,434,767	10,380		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits		5.00
				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		17140	814	394		8.00
8.01	Skilled Nursing Care		99915	1,162	713		8.01
9.00	Physical Therapy		17140	395	268		9.00
9.01	Physical Therapy		99915	444	367		9.01
10.00	Occupational Therapy		17140	155	87		10.00
10.01	Occupational Therapy		99915	146	97		10.01
11.00	Speech Pathology		17140	12	5		11.00
11.01	Speech Pathology		99915	5	10		11.01
12.00	Medical Social Services		17140	0	1		12.00
12.01	Medical Social Services		99915	1	4		12.01
13.00	Home Health Aide		17140	50	120		13.00
13.01	Home Health Aide		99915	73	167		13.01
14.00	Total (sum of lines 8-13)			3,257	2,233		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 (col. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	0	0	13,639	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

Cost Center Description	Part A	Program Visits		Part A	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
	6.00	7.00	8.00	9.00	10.00	11.00

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	1,976	1,107		425,532	238,392	1.00
2.00	Physical Therapy	839	635		221,068	167,316	2.00
3.00	Occupational Therapy	301	184		99,962	61,106	3.00
4.00	Speech Pathology	17	15		2,427	2,142	4.00
5.00	Medical Social Services	1	5		1,888	9,438	5.00
6.00	Home Health Aide	123	287		24,695	57,621	6.00
7.00	Total (sum of lines 1-6)	3,257	2,233		775,572	536,015	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 151329	Period: From 01/01/2012 To 12/31/2012	Worksheet H-3 Part I
				HHA CCN: 157143		Date/Time Prepared: 5/28/2013 9:24 am
				Title XVII I	Home Health Agency I	PPS

Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
14.00	Total (sum of lines 8-13)						14.00

Cost Center Description		Program Covered Charges			Cost of Services		
		Part A	Part B		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		6.00	7.00	8.00	9.00	10.00	11.00

Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies						15.00
16.00	Cost of Drugs		0	0		0	16.00

Cost Center Description		Total Program Cost (sum of col s. 9-10)
		12.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION

Cost Per Visit Computation			
1.00	Skilled Nursing Care	663,924	1.00
2.00	Physical Therapy	388,384	2.00
3.00	Occupational Therapy	161,068	3.00
4.00	Speech Pathology	4,569	4.00
5.00	Medical Social Services	11,326	5.00
6.00	Home Health Aide	82,316	6.00
7.00	Total (sum of lines 1-6)	1,311,587	7.00

Cost Center Description		
		12.00

Limitation Cost Computation			
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151329

Period:

Worksheet H-3

HHA CCN: 157143

From 01/01/2012
To 12/31/2012

Part II
Date/Time Prepared:
5/28/2013 9:24 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.626287	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.823743	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	1.318469	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.000000	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.378256	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151329 HHA CCN: 157143	Period: From 01/01/2012 To 12/31/2012	Worksheet H-4 Part I-II Date/Time Prepared: 5/28/2013 9:24 am	
		Title XVII I	Home Health Agency I	PPS	
		Part A	Part B	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES					
Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)		0	0	0 1.00
2.00	Total charges		0	0	0 2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)		0	0	0 3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)		0	0	0 4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.000000	0.000000	0.000000 5.00
6.00	Total customary charges (see instructions)		0	0	0 6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)		0	0	0 7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)		0	0	0 8.00
9.00	Primary payer amounts		0	0	0 9.00
			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 10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers			597,568	378,294 11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers			0	0 12.00
13.00	Total PPS Reimbursement - LUPA Episodes			16,131	12,175 13.00
14.00	Total PPS Reimbursement - PEP Episodes			2,952	1,587 14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	0 15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes			0	0 16.00
17.00	Total Other Payments			0	0 17.00
18.00	DME Payments			0	0 18.00
19.00	Oxygen Payments			0	0 19.00
20.00	Prosthetic and Orthotic Payments			0	0 20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)				0 21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)			616,651	392,056 22.00
23.00	Excess reasonable cost (from line 8)			0	0 23.00
24.00	Subtotal (line 22 minus line 23)			616,651	392,056 24.00
25.00	Coinsurance billed to program patients (from your records)				0 25.00
26.00	Net cost (line 24 minus line 25)			616,651	392,056 26.00
27.00	Reimbursable bad debts (from your records)			0	0 27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0	0 28.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151329 HHA CCN: 157143	Period: From 01/01/2012 To 12/31/2012	Worksheet H-4 Part I-II Date/Time Prepared: 5/28/2013 9:24 am	
		Title XVIII	Home Health Agency I	PPS	
				Part A Services	Part B Services
				1.00	2.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		616,651	392,056	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)		616,651	392,056	31.00
32.00	Interim payments (see instructions)		616,651	392,056	32.00
33.00	Tentative settlement (for contractor use only)		0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 151329 HHA CCN: 157143	Period: From 01/01/2012 To 12/31/2012	Worksheet H-5 Date/Time Prepared: 5/28/2013 9:24 am		
		Home Health Agency I		PPS		
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		616,651		392,056	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)		616,651		392,056	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)		616,651		392,056	7.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 151329 HHA CCN: 157143	Period: From 01/01/2012 To 12/31/2012	Worksheet H-5 Date/Time Prepared: 5/28/2013 9:24 am
			Home Health Agency I	PPS
			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: 151329

Period: From 01/01/2012

Worksheet K

Hospice CCN: 151551

To 12/31/2012

Date/Time Prepared: 5/28/2013 9:24 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	161,998	0	1,207	0	194,526	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	217,963	0	15,884	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	16,485	0	7	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	43,266	0	4,539	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	30,735	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	87,434	0	0	0	0	20.00
21.00	Other	78	0	2,948	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	527,224	0	55,320	0	194,526	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151329

Period: From 01/01/2012

Worksheet K

Hospice CCN: 151551

To 12/31/2012

Date/Time Prepared: 5/28/2013 9:24 am

		Total (col. 5)	Reclassification	Subtotal (col. 6 ± col. 7)	Hospice I Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	357,731	0	357,731	0	357,731	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	233,847	0	233,847	0	233,847	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	16,492	0	16,492	0	16,492	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	47,805	0	47,805	0	47,805	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	30,735	0	30,735	0	30,735	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	87,434	0	87,434	0	87,434	20.00
21.00	Other	3,026	0	3,026	0	3,026	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	777,070	0	777,070	0	777,070	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151329

Period: From 01/01/2012

Worksheet K-1

Hospice CCN: 151551

To 12/31/2012

Date/Time Prepared: 5/28/2013 9:24 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	161,998	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	217,963	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	43,266	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	161,998	43,266	0	217,963	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151329

Period: From 01/01/2012

Worksheet K-1

Hospice CCN: 151551

To 12/31/2012

Date/Time Prepared: 5/28/2013 9:24 am

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	161,998	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	217,963	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	16,485	0	0	16,485	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	43,266	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		87,434	0	87,434	20.00
21.00	Other		0	78	78	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)	16,485	87,434	78	527,224	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151329
 Hospice CCN: 151551

Period:
 From 01/01/2012
 To 12/31/2012

Worksheet K-4
 Part I
 Date/Time Prepared:
 5/28/2013 9:24 am

		Hospice I				
		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT		
		0	1.00	2.00	3.00	4.00
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0			1.00
2.00	Capital Related Costs-Movable Equip.	0		0		2.00
3.00	Plant Operation and Maintenance	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	5.00
6.00	Administrative and General	357,731	0	0	0	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	233,847	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	16,492	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	47,805	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	30,735	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	87,434	0	0	0	20.00
21.00	Other	3,026	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	777,070	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151329

Period: From 01/01/2012

Worksheet K-4

Hospice CCN: 151551

To 12/31/2012

Part I
Date/Time Prepared:
5/28/2013 9:24 am

		Hospice I			
	VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)	
	5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.				1.00
2.00	Capital Related Costs-Movable Equip.				2.00
3.00	Plant Operation and Maintenance				3.00
4.00	Transportation - Staff				4.00
5.00	Volunteer Service Coordination	0			5.00
6.00	Administrative and General	0	357,731	357,731	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	233,847	199,491	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	11.00
12.00	Physical Therapy	0	0	0	12.00
13.00	Occupational Therapy	0	16,492	14,069	13.00
14.00	Speech/ Language Pathology	0	0	0	14.00
15.00	Medical Social Services	0	47,805	40,782	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	30,735	26,220	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	87,434	74,588	20.00
21.00	Other	0	3,026	2,581	21.00
OTHER HOSPICE SERVICE COSTS					
22.00	Drugs, Biological and Infusion Therapy	0	0	0	22.00
23.00	Analgesics	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	24.00
25.00	Other - Specify	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	26.00
27.00	Patient Transportation	0	0	0	27.00
28.00	Imaging Services	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	29.00
30.00	Medical Supplies	0	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	777,070	777,070	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151329
 Hospice CCN: 151551

Period:
 From 01/01/2012
 To 12/31/2012

Worksheet K-4
 Part II
 Date/Time Prepared:
 5/28/2013 9:24 am

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151329
 Hospice CCN: 151551

Period:
 From 01/01/2012
 To 12/31/2012

Worksheet K-4
 Part II
 Date/Time Prepared:
 5/28/2013 9:24 am

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	Hospice I
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-357,731	419,339	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	233,847	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	16,492	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	47,805	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	30,735	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	87,434	20.00
21.00	Other	0	3,026	21.00
OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		357,731	39.00
40.00	Unit Cost Multiplier		0.853083	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151329

Period: From 01/01/2012

Worksheet K-5

Hospice CCN: 151551

To 12/31/2012

Part I
Date/Time Prepared:
5/28/2013 9:24 am

Hospice I

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSITE	
		1.00	1.01	2.00	2.01	
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	433,338	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	30,561	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	88,587	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	56,955	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	162,022	0	0	0	0	15.00
16.00 Other	5,607	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)	777,070	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: 151329

Period:

Worksheet K-5

Hospice CCN: 151551

From 01/01/2012
To 12/31/2012

Part I
Date/Time Prepared:
5/28/2013 9:24 am

Cost Center Description		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
		4.00	4A	5.00	7.00	7.01	
1.00	Administrative and General	178,946	178,946	41,232	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	433,338	99,848	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	30,561	7,042	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	88,587	20,412	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	56,955	13,123	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	162,022	37,332	0	0	15.00
16.00	Other	0	5,607	1,292	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)	178,946	956,016	220,281	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)		0.000000				35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151329

Period: From 01/01/2012

Worksheet K-5

Hospice CCN: 151551

To 12/31/2012

Part I
Date/Time Prepared:
5/28/2013 9:24 am

Cost Center Description		Hospice I					
		OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.02	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151329

Period: From 01/01/2012

Worksheet K-5

Hospice CCN: 151551

To 12/31/2012

Part I
Date/Time Prepared:
5/28/2013 9:24 am

Cost Center Description		Hospice I				Subtotal (col s. 4A-23)	
		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		13.00	14.00	15.00	16.00	24.00	
1.00	Administrative and General	0	7,254	0	0	227,432	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	533,186	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	37,603	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	108,999	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	70,078	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	199,354	15.00
16.00	Other	0	0	0	0	6,899	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	7,254	0	0	1,183,551	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151329

Period: From 01/01/2012

Worksheet K-5

Hospice CCN: 151551

To 12/31/2012

Part I
Date/Time Prepared:
5/28/2013 9:24 am

Cost Center Description		Hospice I					
		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (col.s. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (col.s. 26 ± 27)		
		25.00	26.00	27.00	28.00		
1.00	Administrative and General						1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	0	0	0		4.00
5.00	Nursing Care	0	533,186	126,829	660,015		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	37,603	8,945	46,548		8.00
9.00	Speech/ Language Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	108,999	25,928	134,927		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	70,078	16,669	86,747		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	199,354	47,420	246,774		15.00
16.00	Other	0	6,899	1,641	8,540		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00	Analgesics	0	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0	0		19.00
20.00	Other - Specify	0	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00	Patient Transportation	0	0	0	0		22.00
23.00	Imaging Services	0	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0	0		24.00
25.00	Medical Supplies	0	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00	Radiation Therapy	0	0	0	0		27.00
28.00	Chemotherapy	0	0	0	0		28.00
29.00	Other	0	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0	0		31.00
32.00	Fundraising	0	0	0	0		32.00
33.00	Other Program Costs	0	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	1,183,551		1,183,551		34.00
35.00	Unit Cost Multiplier (see instructions)			0.237870			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151329
Hospice CCN: 151551

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-5
Part II
Date/Time Prepared:
5/28/2013 9:24 am

Cost Center Description	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS (GROSS SALARIES)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSITE (SQUARE FEET)		
	1.00	1.01	2.00	2.01		
1.00 Administrative and General	0	0	0	0	527,223	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	527,223	34.00
35.00 Total cost to be allocated	0	0	0	0	178,946	35.00
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000	0.339412	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151329
Hospice CCN: 151551

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-5
Part II
Date/Time Prepared:
5/28/2013 9:24 am

Cost Center Description		Hospice I					
		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	
		5A	5.00	7.00	7.01	7.02	
1.00	Administrative and General	0	178,946	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	433,338	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	30,561	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	88,587	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	56,955	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	162,022	0	0	0	15.00
16.00	Other	0	5,607	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)		956,016	0	0	0	34.00
35.00	Total cost to be allocated		220,281	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)		0.230416	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151329
Hospice CCN: 151551

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-5
Part II
Date/Time Prepared:
5/28/2013 9:24 am

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151329
Hospice CCN: 151551

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-5
Part II
Date/Time Prepared:
5/28/2013 9:24 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (100% PHARMACY)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	Hospice I	
		14.00	15.00	16.00		
1.00	Administrative and General	88,466	0	0		1.00
2.00	Inpatient - General Care	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0		3.00
4.00	Physician Services	0	0	0		4.00
5.00	Nursing Care	0	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0		6.00
7.00	Physical Therapy	0	0	0		7.00
8.00	Occupational Therapy	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0		9.00
10.00	Medical Social Services	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0		11.00
12.00	Dietary Counseling	0	0	0		12.00
13.00	Counseling - Other	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0		15.00
16.00	Other	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0		17.00
18.00	Analgesics	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0		19.00
20.00	Other - Specify	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0		21.00
22.00	Patient Transportation	0	0	0		22.00
23.00	Imaging Services	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0		24.00
25.00	Medical Supplies	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0		26.00
27.00	Radiation Therapy	0	0	0		27.00
28.00	Chemotherapy	0	0	0		28.00
29.00	Other	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0		31.00
32.00	Fundraising	0	0	0		32.00
33.00	Other Program Costs	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	88,466	0	0		34.00
35.00	Total cost to be allocated	7,254	0	0		35.00
36.00	Unit Cost Multiplier (see instructions)	0.081998	0.000000	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 151329 Hospice CCN: 151551		Period: From 01/01/2012 To 12/31/2012		Worksheet K-5 Part III Date/Time Prepared: 5/28/2013 9:24 am	
Cost Center Description		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)		
		0	1.00	2.00	3.00		
ANCI LLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.626287	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.823743	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	1.318469	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.378256	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.247140	0	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.000000	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	OTHER ANCI LLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-10)					0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 151329

Period: From 01/01/2012

Worksheet K-6

Hospice CCN: 151551

To 12/31/2012

Date/Time Prepared: 5/28/2013 9:24 am

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				1,183,551	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				9,185	2.00
3.00	Average cost per diem (line 1 divided by line 2)				128.86	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	8,498				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	1,095,052				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		171			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		22,035			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	4,079				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	525,620				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		41			10.00
11.00	Aggregate NF cost (line 3 times line 10)		5,283			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			516		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			66,492		13.00