

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: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet S Parts I-III Date/Time Prepared: 2/27/2013 7:31 pm
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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: 2/27/2013 Time: 7:31 pm
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 FAYETTE REGIONAL HEALTH SYSTEM (150064) for the cost reporting period beginning 10/01/2011 and ending 09/30/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(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	-163,069	-110,043	-75,622	-1,222,896	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	-13,194	0	0	-19,145	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	-176,263	-110,043	-75,622	-1,242,041	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: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/27/2013 7:31 pm					
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1941 VIRGINIA AVENUE			PO Box:						1.00		
2.00	City: CONNERSVILLE			State: IN		Zip Code: 47331-		County: FAYETTE		2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		FAYETTE REGIONAL HEALTH SYSTEM	150064	99915	1	07/01/1966	N	P	O	3.00	
4.00	Subprovider - IPF										4.00	
5.00	Subprovider - IRF		FAYETTE REGIONAL HEALTH SYSTEM	15T064	99915	5	10/01/2003	N	P	O	5.00	
6.00	Subprovider - (Other)										6.00	
7.00	Swing Beds - SNF		FAYETTE REGIONAL HEALTH SYSTEM	15U064	99915		06/25/2009	N	P	P	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		FAYETTE MEMORIAL HOME HEALTH	157097	99915		01/01/1984	N	P	N	12.00	
13.00	Separately Certified ASC										13.00	
14.00	Hospital-Based Hospice		FMH HOME HEALTHCARE & HOSPICE	151548	99915		02/01/1996				14.00	
15.00	Hospital-Based Health Clinic - RHC										15.00	
16.00	Hospital-Based Health Clinic - FOHC										16.00	
17.00	Hospital-Based (CMHC) I										17.00	
17.10	Hospital-Based (CORF) I										17.10	
18.00	Renal Dialysis										18.00	
19.00	Other										19.00	
						From:	To:					
						1.00	2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2011		09/30/2012		20.00		
21.00	Type of Control (see instructions)							2		21.00		
Inpatient PPS Information												
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y		N		22.00		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3		N		23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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.					368	270	6	0	623	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.					20	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: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/27/2013 7:31 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					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.					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: 150064

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

Worksheet S-2
Part I
Date/Time Prepared:
2/27/2013 7:31 pm

		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: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/27/2013 7:31 pm		
		1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N		0		76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N			
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N			
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					
		V	XIX			
		1.00	2.00			
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	419,744	0		118.01
				1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	Y	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.			Y	145.00
				1.00	2.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
161.10	CORF		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150064			Period: From 10/01/2011 To 09/30/2012		Worksheet S-2 Part I Date/Time Prepared: 2/27/2013 7:31 pm		
								1.00	
Multi campus									
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5							0.00	166.00
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							1.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part II Date/Time Prepared: 2/27/2013 7:31 pm
		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
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
		Description	Y/N	Date
		0	1.00	2.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/28/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part II Date/Time Prepared: 2/27/2013 7:31 pm
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		Part A		
		Description	Y/N	Date
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00 N	2.00
				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			22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			31.00
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.			32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			35.00
			Y/N	Date
			1.00	2.00
Home Office Costs				
36.00	Were home office costs claimed on the cost report?			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00
			1.00	2.00
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LISA		ROONEY
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO		
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

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N	11/28/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		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: 150064

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

Worksheet S-3
Part I
Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	45	19,398	0.00		1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		45	19,398	0.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,392	0.00		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00					13.00
14.00 Total (see instructions)		57	23,790	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	40.00	0	0			16.00
17.00 SUBPROVIDER - IRF	41.00	16	5,856			17.00
18.00 SUBPROVIDER	42.00	0	0			18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10					25.10
26.00 RURAL HEALTH CLINIC	88.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00 Total (sum of lines 14-26)		73				27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150064

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

Worksheet S-3
Part I
Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,368	198	2,394		1.00
2.00 HMO		240	891			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	105	0	118		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,473	198	2,512		7.00
8.00 INTENSIVE CARE UNIT	0	883	131	1,599		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		39	473		13.00
14.00 Total (see instructions)	0	2,356	368	4,584		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF	0	0	0	0		16.00
17.00 SUBPROVIDER - IRF	0	760	20	966		17.00
18.00 SUBPROVIDER	0	0	0	0		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	5,066	400	16,311		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE		0	0	0		24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0		25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	581		28.00
29.00 Ambulance Trips		17,367				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			8	12		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150064

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

Worksheet S-3
Part I
Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	797	1.00
2.00 HMO					81	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	445.30	0.00	0	797	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0.00	0.00	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	7.80	0.00	0	60	17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	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	0.00	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00	0.00	0.00			24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	453.10	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150064

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

Worksheet S-3
Part I
Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	118	1,486		1.00
2.00 HMO				2.00
3.00 HMO IPF Subprovider				3.00
4.00 HMO IRF Subprovider				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF				5.00
6.00 Hospital Adults & Peds. Swing Bed NF				6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00 INTENSIVE CARE UNIT				8.00
9.00 CORONARY CARE UNIT				9.00
10.00 BURN INTENSIVE CARE UNIT				10.00
11.00 SURGICAL INTENSIVE CARE UNIT				11.00
12.00 OTHER SPECIAL CARE (SPECIFY)				12.00
13.00 NURSERY				13.00
14.00 Total (see instructions)	118	1,486		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF	0	0		16.00
17.00 SUBPROVIDER - IRF	1	73		17.00
18.00 SUBPROVIDER	0	0		18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
25.10 CMHC - CORF				25.10
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet S-3 Part II Date/Time Prepared: 2/27/2013 7:31 pm			
	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	24,095,006	0	24,095,006	1,019,556.00	23.63	1.00
2.00	Non-physician anesthetist Part A		12,530	0	12,530	117.00	107.09	2.00
3.00	Non-physician anesthetist Part B		432,984	0	432,984	4,043.00	107.09	3.00
4.00	Physician-Part A - Administrative		375,145	0	375,145	2,477.00	151.45	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		2,435,117	0	2,435,117	3,416.00	712.86	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		6,002,177	146,576	6,148,753	236,239.00	26.03	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		533,812	0	533,812	6,622.00	80.61	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		74,000	0	74,000	2,201.00	33.62	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		3,488,599	0	3,488,599			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0			18.00
19.00	Excluded areas		1,174,818	0	1,174,818			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		41,804	0	41,804			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		238,130	0	238,130			23.00
24.00	Wage-related costs (RHC/FOHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits	4.00	180,551	116,437	296,988	9,689.00	30.65	26.00
27.00	Administrative & General	5.00	2,152,216	-632,656	1,519,560	88,264.00	17.22	27.00
28.00	Administrative & General under contract (see inst.)		643,472	0	643,472	15,104.00	42.60	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	346,984	10,755	357,739	27,314.00	13.10	30.00
31.00	Laundry & Linen Service	8.00	21,619	450	22,069	2,017.00	10.94	31.00
32.00	Housekeeping	9.00	562,596	11,714	574,310	57,299.00	10.02	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	481,971	-296,863	185,108	13,847.00	13.37	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	306,898	306,898	23,784.00	12.90	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	427,210	6,914	434,124	13,670.00	31.76	38.00
39.00	Central Services and Supply	14.00	89,040	1,854	90,894	5,807.00	15.65	39.00
40.00	Pharmacy	15.00	694,516	11,240	705,756	19,836.00	35.58	40.00
41.00	Medical Records & Medical Records Library	16.00	715,024	48,655	763,679	38,244.00	19.97	41.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150064

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

Worksheet S-3
Part II
Date/Time Prepared:
2/27/2013 7:31 pm

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Soci al Servi ce	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Servi ce	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150064

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

Worksheet S-3
Part III
Date/Time Prepared:
2/27/2013 7:31 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	21,857,847	0	21,857,847	1,027,084.00	21.28	1.00
2.00	Excluded area salaries (see instructions)	6,002,177	146,576	6,148,753	236,239.00	26.03	2.00
3.00	Subtotal salaries (line 1 minus line 2)	15,855,670	-146,576	15,709,094	790,845.00	19.86	3.00
4.00	Subtotal other wages & related costs (see inst.)	607,812	0	607,812	8,823.00	68.89	4.00
5.00	Subtotal wage-related costs (see inst.)	3,530,403	0	3,530,403	0.00	22.47	5.00
6.00	Total (sum of lines 3 thru 5)	19,993,885	-146,576	19,847,309	799,668.00	24.82	6.00
7.00	Total overhead cost (see instructions)	6,315,199	-414,602	5,900,597	314,875.00	18.74	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet S-3 Part IV Date/Time Prepared: 2/27/2013 7:31 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		440,538	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		3,126,943	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		-169,163	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		-94,378	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		-187,582	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		175,808	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		1,564,589	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		64,925	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		21,670	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		4,943,350	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet S-3 Part V Date/Time Prepared: 2/27/2013 7:31 pm
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0 1.00
2.00	Hospital		0	0 2.00
3.00	Subprovider - IPF		0	0 3.00
4.00	Subprovider - IRF		0	0 4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA		0	0 11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice		0	0 13.00
14.00	Hospital-Based Health Clinic RHC		0	0 14.00
15.00	Hospital-Based Health Clinic FQHC		0	0 15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10		0	0 16.10
17.00	Renal Dialysis		0	0 17.00
18.00	Other		0	0 18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 150064 Component CCN: 157097		Period: From 10/01/2011 To 09/30/2012		Worksheet S-4 Date/Time Prepared: 2/27/2013 7:31 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County			FAYETTE		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	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	238.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
				0	1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99915			20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	2,313	142	111	41	2,607	21.00
22.00	Skilled Nursing Visit Charges	265,995	16,330	12,765	4,715	299,805	22.00
23.00	Physical Therapy Visits	547	3	15	5	570	23.00
24.00	Physical Therapy Visit Charges	68,375	375	1,875	625	71,250	24.00
25.00	Occupational Therapy Visits	536	3	4	1	544	25.00
26.00	Occupational Therapy Visit Charges	67,000	375	500	125	68,000	26.00
27.00	Speech Pathology Visits	22	0	0	0	22	27.00
28.00	Speech Pathology Visit Charges	2,970	0	0	0	2,970	28.00
29.00	Medical Social Service Visits	39	0	3	1	43	29.00
30.00	Medical Social Service Visit Charges	7,020	0	540	180	7,740	30.00
31.00	Home Health Aide Visits	1,224	8	9	39	1,280	31.00
32.00	Home Health Aide Visit Charges	84,456	552	621	2,691	88,320	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,681	156	142	87	5,066	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	495,816	17,632	16,301	8,336	538,085	35.00
36.00	Total Number of Episodes (standard/non outlier)	277		54	5	336	36.00
37.00	Total Number of Outlier Episodes		4		1	5	37.00
38.00	Total Non-Routine Medical Supply Charges	12,445	1,150	865	685	15,145	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150064

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

Worksheet S-7

Date/Time Prepared:
2/27/2013 7:31 pm

		1.00	2.00	1.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00	
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	0	0	0	7.00
8.00	RHL	0	0	0	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	0	0	0	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	0	0	0	14.00
15.00	RVC	0	0	0	15.00
16.00	RVB	0	0	0	16.00
17.00	RVA	0	19	19	17.00
18.00	RHC	0	0	0	18.00
19.00	RHB	0	0	0	19.00
20.00	RHA	0	10	10	20.00
21.00	RMC	0	0	0	21.00
22.00	RMB	0	0	0	22.00
23.00	RMA	0	52	52	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	0	0	0	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	0	0	0	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	0	0	0	32.00
33.00	HC2	0	0	0	33.00
34.00	HC1	0	0	0	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	0	4	4	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	0	0	0	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	0	0	0	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	0	0	0	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	0	0	0	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	0	8	8	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	0	0	0	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	0	7	7	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	0	5	5	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150064

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

Worksheet S-7

Date/Time Prepared:
2/27/2013 7:31 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	105	105	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).		99915	99915	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

HOSPITAL IDENTIFICATION DATA		Provider CCN: 150064 Component CCN: 151548		Period: From 10/01/2011 To 09/30/2012		Worksheet S-9 Parts I & II Date/Time Prepared: 2/27/2013 7:31 pm	
		Unduplicated Days				Hospice I	
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	
		1.00	2.00	3.00	4.00	5.00	
PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	
2.00	Routine Home Care	1,100	0	0	0	0	
3.00	Inpatient Respite Care	0	0	0	0	0	
4.00	General Inpatient Care	0	0	0	0	0	
5.00	Total Hospice Days	1,100	0	0	0	0	
Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	0	0	0	0	0	
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00		7.00	
8.00	Average Length of Stay (line 5/line 6)	0.00	0.00	0.00	0.00	0.00	
9.00	Unduplicated Census Count	0	0	0	0	0	

HOSPITAL IDENTIFICATION DATA		Provider CCN: 150064 Component CCN: 151548	Period: From 10/01/2011 To 09/30/2012	Worksheet S-9 Parts I & II Date/Time Prepared: 2/27/2013 7:31 pm
		Hospice I		

		Unduplicated Days	
		Total (sum of cols. 1, 2 & 5)	
		6.00	
PART I - ENROLLMENT DAYS			
1.00	Continuous Home Care	0	1.00
2.00	Routine Home Care	1,100	2.00
3.00	Inpatient Respite Care	0	3.00
4.00	General Inpatient Care	0	4.00
5.00	Total Hospice Days	1,100	5.00
Part II - CENSUS DATA			
6.00	Number of Patients Receiving Hospice Care	0	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare		7.00
8.00	Average Length of Stay (line 5/line 6)	0.00	8.00
9.00	Unduplicated Census Count	0	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet S-10 Date/Time Prepared: 2/27/2013 7:31 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.363433	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		6,653,411	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		2,149,824	5.00	
6.00	Medicaid charges		21,370,352	6.00	
7.00	Medicaid cost (line 1 times line 6)		7,766,691	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)		0	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)		0	19.00	
			1.00		
			2.00		
			3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,617,256	0	1,617,256	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	587,764	0	587,764	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)	587,764	0	587,764	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		5,351,943	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		224,945	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		5,126,998	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		1,863,320	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,451,084	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,451,084	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150064

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

Worksheet A
Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT		2,498,180	2,498,180	0	2,498,180	1.00	
4.00 00400 EMPLOYEE BENEFITS	180,551	5,289,499	5,470,050	116,437	5,586,487	4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	2,152,216	4,775,595	6,927,811	-597,003	6,330,808	5.00	
7.00 00700 OPERATION OF PLANT	346,984	1,783,038	2,130,022	-798,209	1,331,813	7.00	
7.01 00701 OPERATION OF PLANT	0	0	0	808,964	808,964	7.01	
8.00 00800 LAUNDRY & LINEN SERVICE	21,619	141,584	163,203	450	163,653	8.00	
9.00 00900 HOUSEKEEPING	562,596	139,060	701,656	11,714	713,370	9.00	
10.00 01000 DIETARY	481,971	344,679	826,650	-516,340	310,310	10.00	
11.00 01100 CAFETERIA	0	0	0	526,375	526,375	11.00	
13.00 01300 NURSING ADMINISTRATION	427,210	8,735	435,945	6,914	442,859	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	89,040	1,030,653	1,119,693	-61,048	1,058,645	14.00	
15.00 01500 PHARMACY	694,516	1,188,986	1,883,502	11,240	1,894,742	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	715,024	312,678	1,027,702	48,655	1,076,357	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	1,561,492	195,207	1,756,699	-337,779	1,418,920	30.00	
31.00 03100 INTENSIVE CARE UNIT	931,633	67,380	999,013	15,077	1,014,090	31.00	
40.00 04000 SUBPROVIDER - I/PF	0	0	0	0	0	40.00	
41.00 04100 SUBPROVIDER - I/RF	394,597	113,563	508,160	6,386	514,546	41.00	
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00	
43.00 04300 NURSERY	0	0	0	363,050	363,050	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	1,664,243	526,342	2,190,585	26,934	2,217,519	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,261,480	2,519,308	3,780,788	24,044	3,804,832	54.00	
57.00 05700 CT SCAN	0	0	0	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	753,485	1,055,501	1,808,986	15,688	1,824,674	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
65.00 06500 RESPIRATORY THERAPY	398,064	54,742	452,806	6,442	459,248	65.00	
66.00 06600 PHYSICAL THERAPY	833,480	25,130	858,610	13,489	872,099	66.00	
69.01 06901 CARDIAC REHAB	140,828	20,551	161,379	2,279	163,658	69.01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	62,902	62,902	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
91.00 09100 EMERGENCY	1,103,506	699,424	1,802,930	17,859	1,820,789	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
93.00 04040 CLINIC	2,785,309	531,683	3,316,992	89,232	3,406,224	93.00	
93.01 04044 BIC	987,582	983,282	1,970,864	31,711	2,002,575	93.01	
93.02 04041 UIC	0	0	0	0	0	93.02	
93.03 04042 CIC	0	0	0	0	0	93.03	
93.04 04043 RIC	0	0	0	0	0	93.04	
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	530,524	175,104	705,628	8,545	714,173	95.00	
99.10 09910 CORF	0	0	0	0	0	99.10	
101.00 10100 HOME HEALTH AGENCY	797,459	122,339	919,798	-31,980	887,818	101.00	
SPECIAL PURPOSE COST CENTERS							
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00	
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00	
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00	
116.00 11600 HOSPICE	0	39,994	39,994	44,927	84,921	116.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	19,815,409	24,642,237	44,457,646	-83,045	44,374,601	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
191.00 19100 RESEARCH	0	0	0	0	0	191.00	
191.01 19101 FMH DIAGNOSTIC CENTE	158,624	10,039	168,663	5,093	173,756	191.01	
191.02 19102 WELLNESS	90,410	129,927	220,337	1,463	221,800	191.02	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	2,095,672	1,397,345	3,493,017	62,585	3,555,602	192.00	
192.01 19201 RFE	0	3,158	3,158	0	3,158	192.01	
192.02 19202 MARKETING	28,692	268,964	297,656	-38,747	258,909	192.02	
192.03 19203 FOUNDATION	0	0	0	0	0	192.03	
192.04 19204 BROOKVILLE CLINIC	0	0	0	0	0	192.04	
192.05 19205 ATOD	0	0	0	0	0	192.05	
192.06 19206 HEART CENTER	0	0	0	0	0	192.06	
192.07 19207 WVCP	1,371,971	581,443	1,953,414	44,005	1,997,419	192.07	
192.08 19210 OCCUPATIONAL MED	0	1,605	1,605	0	1,605	192.08	
192.09 19209 HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.09	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 150064		Period: From 10/01/2011 To 09/30/2012		Worksheet A Date/Time Prepared: 2/27/2013 7:31 pm	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
192.10	19211 HOSPITALIST	534,228	933,055	1,467,283	8,646	1,475,929	192.10
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00	TOTAL (SUM OF LINES 118-199)	24,095,006	27,967,773	52,062,779	0	52,062,779	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150064

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

Worksheet A
Date/Time Prepared:
2/27/2013 7:31 pm

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	-613,170	1,885,010	1.00
4.00	00400	EMPLOYEE BENEFITS	0	5,586,487	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-128,073	6,202,735	5.00
7.00	00700	OPERATION OF PLANT	-2,075	1,329,738	7.00
7.01	00701	OPERATION OF PLANT	0	808,964	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	163,653	8.00
9.00	00900	HOUSEKEEPING	0	713,370	9.00
10.00	01000	DIETARY	0	310,310	10.00
11.00	01100	CAFETERIA	-215,001	311,374	11.00
13.00	01300	NURSING ADMINISTRATION	-1,164	441,695	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,058,645	14.00
15.00	01500	PHARMACY	-173,553	1,721,189	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-11,460	1,064,897	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,418,920	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,014,090	31.00
40.00	04000	SUBPROVIDER - I PF	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	514,546	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	363,050	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-752,820	1,464,699	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,804,832	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	1,824,674	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	-5,963	453,285	65.00
66.00	06600	PHYSICAL THERAPY	-111,309	760,790	66.00
69.01	06901	CARDIAC REHAB	0	163,658	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	62,902	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	09100	EMERGENCY	-615,662	1,205,127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	CLINIC	-1,933,949	1,472,275	93.00
93.01	04044	BIC	-395,085	1,607,490	93.01
93.02	04041	UCIC	0	0	93.02
93.03	04042	CIC	0	0	93.03
93.04	04043	RIC	0	0	93.04
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-51,175	662,998	95.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	887,818	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
116.00	11600	HOSPICE	0	84,921	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-5,010,459	39,364,142	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
191.01	19101	FMH DIAGNOSTIC CENTE	0	173,756	191.01
191.02	19102	WELLNESS	0	221,800	191.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,555,602	192.00
192.01	19201	RFE	0	3,158	192.01
192.02	19202	MARKETING	0	258,909	192.02
192.03	19203	FOUNDATION	0	0	192.03
192.04	19204	BROOKVILLE CLINIC	0	0	192.04
192.05	19205	ATOD	0	0	192.05
192.06	19206	HEART CENTER	0	0	192.06
192.07	19207	WVCP	0	1,997,419	192.07
192.08	19210	OCCUPATIONAL MED	0	1,605	192.08
192.09	19209	HOME MEDICAL EQUIPMENT	0	0	192.09
192.10	19211	HOSPITALIST	0	1,475,929	192.10
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 150064		Period: From 10/01/2011 To 09/30/2012	Worksheet A Date/Time Prepared: 2/27/2013 7:31 pm
Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
200.00	TOTAL (SUM OF LINES 118-199)	-5,010,459	47,052,320	200.00	

RECLASSIFICATIONS

Provider CCN: 150064

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

Worksheet A-6

Date/Time Prepared:
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		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	306,898	219,477	1.00	
	TOTALS		306,898	219,477		
B - NURSERY RECLASS						
1.00	NURSERY	43.00	331,569	31,481	1.00	
	TOTALS		331,569	31,481		
C - COACH RECLASS						
1.00	EMPLOYEE BENEFITS	4.00	116,437	0	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	165,155	0	2.00	
3.00	OPERATION OF PLANT	7.00	10,755	0	3.00	
4.00	LAUNDRY & LINEN SERVICE	8.00	450	0	4.00	
5.00	HOUSEKEEPING	9.00	11,714	0	5.00	
6.00	DIETARY	10.00	10,035	0	6.00	
7.00	NURSING ADMINISTRATION	13.00	6,914	0	7.00	
8.00	CENTRAL SERVICES & SUPPLY	14.00	1,854	0	8.00	
9.00	PHARMACY	15.00	11,240	0	9.00	
10.00	MEDICAL RECORDS & LIBRARY	16.00	48,655	0	10.00	
11.00	ADULTS & PEDIATRICS	30.00	25,271	0	11.00	
12.00	INTENSIVE CARE UNIT	31.00	15,077	0	12.00	
13.00	SUBPROVIDER - IRF	41.00	6,386	0	13.00	
14.00	OPERATING ROOM	50.00	26,934	0	14.00	
15.00	RADIOLOGY-DIAGNOSTIC	54.00	24,044	0	15.00	
16.00	LABORATORY	60.00	15,688	0	16.00	
17.00	RESPIRATORY THERAPY	65.00	6,442	0	17.00	
18.00	PHYSICAL THERAPY	66.00	13,489	0	18.00	
19.00	CARDIAC REHAB	69.01	2,279	0	19.00	
20.00	EMERGENCY	91.00	17,859	0	20.00	
21.00	CLINIC	93.00	89,232	0	21.00	
22.00	BIC	93.01	31,711	0	22.00	
23.00	AMBULANCE SERVICES	95.00	8,545	0	23.00	
24.00	HOME HEALTH AGENCY	101.00	12,947	0	24.00	
25.00	FMH DIAGNOSTIC CENTE	191.01	5,093	0	25.00	
26.00	WELLNESS	191.02	1,463	0	26.00	
27.00	PHYSICIANS' PRIVATE OFFICES	192.00	62,585	0	27.00	
28.00	MARKETING	192.02	921	0	28.00	
29.00	WVCP	192.07	44,005	0	29.00	
30.00	HOSPITALIST	192.10	8,646	0	30.00	
	TOTALS		801,826	0		
D - MARKETING RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	4,015	35,653	1.00	
	TOTALS		4,015	35,653		
E - HOSPICE RECLASS						
1.00	HOSPICE	116.00	44,927	0	1.00	
	TOTALS		44,927	0		
F - HOSPITAL RECLASS						
1.00	OPERATION OF PLANT	7.01	0	808,964	1.00	
	TOTALS		0	808,964		
G - IMPLANTABLE DEVICES						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	62,902	1.00	
	TOTALS		0	62,902		
500.00	Grand Total: Increases		1,489,235	1,158,477	500.00	

RECLASSIFICATIONS

Provider CCN: 150064

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

Worksheet A-6

Date/Time Prepared:
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA RECLASS							
1.00	DIETARY	10.00	306,898	219,477	0		1.00
	TOTALS		306,898	219,477			
B - NURSERY RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	331,569	31,481	0		1.00
	TOTALS		331,569	31,481			
C - COACH RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	801,826	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
	TOTALS		801,826	0			
D - MARKETING RECLASS							
1.00	MARKETING	192.02	4,015	35,653	0		1.00
	TOTALS		4,015	35,653			
E - HOSPICE RECLASS							
1.00	HOME HEALTH AGENCY	101.00	44,927	0	0		1.00
	TOTALS		44,927	0			
F - HOSPITAL RECLASS							
1.00	OPERATION OF PLANT	7.00	0	808,964	0		1.00
	TOTALS		0	808,964			
G - IMPLANTABLE DEVICES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	62,902	0		1.00
	TOTALS		0	62,902			
500.00	Grand Total : Decreases		1,489,235	1,158,477			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150064

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/27/2013 7:31 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,780,065	5,755	0	5,755	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	51,711,417	30,913	0	30,913	0	3.00
4.00	Building Improvements	35,713	162,692	0	162,692	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	22,102,522	1,106,197	0	1,106,197	577,678	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	75,629,717	1,305,557	0	1,305,557	577,678	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	75,629,717	1,305,557	0	1,305,557	577,678	10.00
SUMMARY OF CAPITAL							
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,156,775	0	1,341,405	0	0	1.00
3.00	Total (sum of lines 1-2)	1,156,775	0	1,341,405	0	0	3.00
COMPUTATION OF RATIOS							
Cost Center Description		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	51,742,330	0	51,742,330	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	51,742,330	0	51,742,330	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150064

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
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		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,785,820	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	51,742,330	0			3.00
4.00	Building Improvements	198,405	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	22,631,041	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	76,357,596	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	76,357,596	0			10.00
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,498,180			1.00
3.00	Total (sum of lines 1-2)	0	2,498,180			3.00
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,118,323	0 1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,118,323	0 3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150064

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,233,618	0	0	-466,931	1,885,010	1.00
3.00	Total (sum of lines 1-2)	1,233,618	0	0	-466,931	1,885,010	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150064

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

Worksheet A-8
Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
			Cost Center	Line #
			1.00	2.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			*** Cost Center Deleted ***	2.00 2.00
3.00 Investment income - other (chapter 2)		0		0.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00 7.00
8.00 Television and radio service (chapter 21)		0		0.00 8.00
9.00 Parking lot (chapter 21)		0		0.00 9.00
10.00 Provider-based physician adjustment	A-8-2	-3,052,173		
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0		12.00
13.00 Laundry and linen service		0		0.00 13.00
14.00 Cafeteria-employees and guests		0		0.00 14.00
15.00 Rental of quarters to employee and others		0		0.00 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00 Sale of drugs to other than patients		0		0.00 17.00
18.00 Sale of medical records and abstracts	A	-11,460	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00 Vending machines		0		0.00 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY	65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			*** Cost Center Deleted ***	2.00 27.00
28.00 Non-physician Anesthetist			*** Cost Center Deleted ***	19.00 28.00
29.00 Physicians' assistant				0.00 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		*** Cost Center Deleted ***	67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		*** Cost Center Deleted ***	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest				0.00 32.00
33.00 INVESTMENT FEE EXP-N/O REV	B	268,124	NEW CAP REL COSTS-BLDG & FIXT	1.00 33.00
34.00 INTEREST INCOME OPER-N/O REV	B	-107,787	NEW CAP REL COSTS-BLDG & FIXT	1.00 34.00
35.00 GAIN OF SALE INVEST-N/O REV	B	-919,594	NEW CAP REL COSTS-BLDG & FIXT	1.00 35.00
36.00 LOSS ON SALE INVEST-N/O REV	B	500,337	NEW CAP REL COSTS-BLDG & FIXT	1.00 36.00
37.00 DIVIDEND INCOME OPER-N/O REV	B	-315,798	NEW CAP REL COSTS-BLDG & FIXT	1.00 37.00
38.00 VENDOR REBATE/REFUND-OTHER REV	B	-5,148	ADMINISTRATIVE & GENERAL	5.00 38.00
39.00 PURCHASE DISC EARNED-OTHER REV	B	10,093	ADMINISTRATIVE & GENERAL	5.00 39.00
40.00 CAFETERIA SALES-OTHER REV	B	-207,577	CAFETERIA	11.00 40.00
41.00 CAFÉ VEND MACHIN-OTHER REV	B	-7,424	CAFETERIA	11.00 41.00
42.00 EDUCATION & TRAINING-OTHER REV	B	-1,164	NURSING ADMINISTRATION	13.00 42.00
43.00 EMPLOYEE DRUG SALES-OTHER REV	B	-167,903	PHARMACY	15.00 43.00
44.00 PHARMACY STUDENT REIMB - OTHER REV	B	-5,650	PHARMACY	15.00 44.00
45.00 AQUATIC THERAPY-OTHER REV	B	-4,690	PHYSICAL THERAPY	66.00 45.00
45.01 OCCUPATION MED-OTHER REV	B	-3,410	PHYSICAL THERAPY	66.00 45.01
45.02 PHY TH SCHOOL REV-OTHER REV	B	-102,100	PHYSICAL THERAPY	66.00 45.02
45.03 PHYSICAL NIGHT-OTHER REV	B	-1,109	PHYSICAL THERAPY	66.00 45.03

ADJUSTMENTS TO EXPENSES

Provider CCN: 150064

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

Worksheet A-8

Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center			Line #
			1.00	2.00		3.00
45.04 MEDICAL STAFF SVCS- OTHER REV	B	-11,137	ADMINISTRATIVE & GENERAL	5.00	45.04	
45.05 HELPLINE -OTHER REV	B	-51,175	AMBULANCE SERVICES	95.00	45.05	
45.06 EKG FEES BILLING SVC - OTHER REV	B	-4,006	RESPIRATORY THERAPY	65.00	45.06	
45.07 STRESS/CARDIOLITE -OTHER REV	B	-1,957	RESPIRATORY THERAPY	65.00	45.07	
45.08 PFS BILLING SVC -OTHER REV	B	-1,110	ADMINISTRATIVE & GENERAL	5.00	45.08	
45.09 IHHA DUES	A	-1,454	ADMINISTRATIVE & GENERAL	5.00	45.09	
45.10 ANESTHESIA OFFSET	A	-29,681	OPERATING ROOM	50.00	45.10	
45.11 TELEVISION	A	-14,345	ADMINISTRATIVE & GENERAL	5.00	45.11	
45.12 TELEVISION ELECTRICITY	A	-2,075	OPERATION OF PLANT	7.00	45.12	
45.13 24TH ST OLD DEPRECIATION	A	-18,346	NEW CAP REL COSTS-BLDG & FIXT	1.00	45.13	
45.14 24TH ST NEW DEPRECIATION	A	-20,106	NEW CAP REL COSTS-BLDG & FIXT	1.00	45.14	
45.15 PHYSICIAN RECRUITMENT	A	-104,972	ADMINISTRATIVE & GENERAL	5.00	45.15	
45.16 ER PURCHASED SERVICES	A	-615,662	EMERGENCY	91.00	45.16	
45.17		0		0.00	45.17	
45.18		0		0.00	45.18	
45.19		0		0.00	45.19	
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,010,459			50.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 150064

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

Worksheet A-8

Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center	Description	Wkst.	A-7 Ref.	
		5.00		
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	2.00
3.00	Investment income - other (chapter 2)		0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0	7.00
8.00	Television and radio service (chapter 21)		0	8.00
9.00	Parking lot (chapter 21)		0	9.00
10.00	Provider-based physician adjustment		0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0	11.00
12.00	Related organization transactions (chapter 10)		0	12.00
13.00	Laundry and linen service		0	13.00
14.00	Cafeteria-employees and guests		0	14.00
15.00	Rental of quarters to employee and others		0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0	16.00
17.00	Sale of drugs to other than patients		0	17.00
18.00	Sale of medical records and abstracts		0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0	19.00
20.00	Vending machines		0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	27.00
28.00	Non-physician Anesthetist			28.00
29.00	Physicians' assistant		0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0	32.00
33.00	INVESTMENT FEE EXP-N/O REV		14	33.00
34.00	INTEREST INCOME OPER-N/O REV		11	34.00
35.00	GAIN OF SALE INVEST-N/O REV		14	35.00
36.00	LOSS ON SALE INVEST-N/O REV		14	36.00
37.00	DIVIDEND INCOME OPER-N/O REV		14	37.00
38.00	VENDOR REBATE/REFUND-OTHER REV		11	38.00
39.00	PURCHASE DISC EARNED-OTHER REV		0	39.00
40.00	CAFETERIA SALES-OTHER REV		0	40.00
41.00	CAFÉ VEND MACHIN-OTHER REV		0	41.00
42.00	EDUCATION & TRAINING-OTHER REV		0	42.00
43.00	EMPLOYEE DRUG SALES-OTHER REV		0	43.00
44.00	PHARMACY STUDENT REIMB - OTHER REV		0	44.00
45.00	AQUATIC THERAPY-OTHER REV		0	45.00
45.01	OCCUPATION MED-OTHER REV		0	45.01
45.02	PHY TH SCHOOL REV-OTHER REV		0	45.02
45.03	PHYSICAL NIGHT-OTHER REV		0	45.03
45.04	MEDICAL STAFF SVCS- OTHER REV		0	45.04
45.05	HELPLINE -OTHER REV		0	45.05
45.06	EKG FEES BILLING SVC - OTHER REV		0	45.06
45.07	STRESS/CARDIOLITE -OTHER REV		0	45.07
45.08	PFS BILLING SVC -OTHER REV		0	45.08
45.09	IHHA DUES		0	45.09
45.10	ANESTHESIA OFFSET		0	45.10
45.11	TELEVISION		0	45.11
45.12	TELEVISION ELECTRICITY		0	45.12
45.13	24TH ST OLD DEPRECIATION		9	45.13
45.14	24TH ST NEW DEPRECIATION		9	45.14
45.15	PHYSICIAN RECRUITMENT		0	45.15

ADJUSTMENTS TO EXPENSES

Provider CCN: 150064

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

Worksheet A-8

Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
45.16	ER PURCHASED SERVICES	0	45.16
45.17		0	45.17
45.18		0	45.18
45.19		0	45.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150064

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

Worksheet A-8-2

Date/Time Prepared:
2/27/2013 7:31 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	50.00	OPERATING ROOM	840,353	597,089	1.00
2.00	93.00	CLINIC	1,933,949	1,933,949	2.00
3.00	93.01	BIC	481,476	337,064	3.00
4.00	0.00		0	0	4.00
5.00	0.00		0	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			3,255,778	2,868,102	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150064

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

Worksheet A-8-2

Date/Time Prepared:
2/27/2013 7:31 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	243,264	182,900	1,333	117,214	5,861	1.00
2.00	0	142,500	0	0	0	2.00
3.00	144,412	142,500	1,261	86,391	4,320	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	387,676		2,594	203,605	10,181	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150064

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

Worksheet A-8-2

Date/Time Prepared:
2/27/2013 7:31 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	117,214	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	86,391	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	203,605	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150064

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

Worksheet A-8-2
Date/Time Prepared:
2/27/2013 7:31 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	126,050	723,139	1.00
2.00	0	1,933,949	2.00
3.00	58,021	395,085	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	184,071	3,052,173	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150064

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

Worksheet B
Part I
Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,885,010	1,885,010				1.00
4.00 00400	EMPLOYEE BENEFITS	5,586,487	7,545	5,594,032			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,202,735	157,679	357,192	6,717,606	6,717,606	5.00
7.00 00700	OPERATION OF PLANT	1,329,738	762,204	84,091	2,176,033	362,412	7.00
7.01 00701	OPERATION OF PLANT	808,964	0	0	808,964	134,731	7.01
8.00 00800	LAUNDRY & LINEN SERVICE	163,653	1,944	5,188	170,785	28,444	8.00
9.00 00900	HOUSEKEEPING	713,370	9,029	134,999	857,398	142,797	9.00
10.00 01000	DIETARY	310,310	11,922	43,512	365,744	60,914	10.00
11.00 01100	CAFETERIA	311,374	20,895	72,140	404,409	67,353	11.00
13.00 01300	NURSING ADMINISTRATION	441,695	0	102,046	543,741	90,558	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,058,645	12,743	21,366	1,092,754	181,995	14.00
15.00 01500	PHARMACY	1,721,189	12,330	165,897	1,899,416	316,342	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,064,897	14,303	179,513	1,258,713	209,635	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	1,418,920	71,140	295,050	1,785,110	297,305	30.00
31.00 03100	INTENSIVE CARE UNIT	1,014,090	44,061	222,536	1,280,687	213,295	31.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	514,546	45,199	94,256	654,001	108,922	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	363,050	25,125	77,940	466,115	77,630	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	1,464,699	118,559	397,533	1,980,791	329,895	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,804,832	105,793	302,179	4,212,804	701,608	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	1,824,674	33,860	180,804	2,039,338	339,646	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	453,285	15,911	95,084	564,280	93,979	65.00
66.00 06600	PHYSICAL THERAPY	760,790	28,767	199,091	988,648	164,656	66.00
69.01 06901	CARDIAC REHAB	163,658	14,142	33,639	211,439	35,215	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	62,902	0	0	62,902	10,476	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 09100	EMERGENCY	1,205,127	38,271	263,591	1,506,989	250,984	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040	CLINIC	1,472,275	72,293	675,698	2,220,266	369,779	93.00
93.01 04044	BIC	1,607,490	0	239,598	1,847,088	307,627	93.01
93.02 04041	UCIC	0	0	0	0	0	93.02
93.03 04042	CIC	0	0	0	0	0	93.03
93.04 04043	RIC	0	0	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	662,998	0	126,715	789,713	131,524	95.00
99.10 09910	CORF	0	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	887,818	12,510	179,936	1,080,264	179,915	101.00
SPECIAL PURPOSE COST CENTERS							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
116.00 11600	HOSPICE	84,921	0	10,561	95,482	15,902	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	39,364,142	1,636,225	4,560,155	38,081,480	5,223,539	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
191.01 19101	FMH DIAGNOSTIC CENTE	173,756	0	38,484	212,240	35,348	191.01
191.02 19102	WELLNESS	221,800	0	21,596	243,396	40,537	191.02
192.00 19200	PHYSICIANS' PRIVATE OFFICES	3,555,602	64,904	507,326	4,127,832	687,478	192.00
192.01 19201	RFE	3,158	0	0	3,158	526	192.01
192.02 19202	MARKETING	258,909	5,748	6,017	270,674	45,080	192.02
192.03 19203	FOUNDATION	0	1,968	0	1,968	328	192.03
192.04 19204	BROOKVILLE CLINIC	0	0	0	0	0	192.04
192.05 19205	ATOD	0	0	0	0	0	192.05
192.06 19206	HEART CENTER	0	4,472	0	4,472	745	192.06

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150064

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

Worksheet B
Part I
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
192.07 19207 WVCP	1,997,419	99,988		332,844	2,430,251	404,751	192.07
192.08 19210 OCCUPATIONAL MED	1,605	0		0	1,605	267	192.08
192.09 19209 HOME MEDICAL EQUIPMENT	0	0		0	0	0	192.09
192.10 19211 HOSPITALIST	1,475,929	0		127,610	1,603,539	267,065	192.10
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	71,705		0	71,705	11,942	194.00
200.00 Cross Foot Adjustments					0		200.00
201.00 Negative Cost Centers					0		201.00
202.00 TOTAL (sum lines 118-201)	47,052,320	1,885,010		5,594,032	47,052,320	6,717,606	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150064

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

Worksheet B
Part I
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Cost Center Description		OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		7.00	7.01	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	2,538,445				7.00	
7.01	00701	OPERATION OF PLANT	0	943,695			7.01	
8.00	00800	LAUNDRY & LINEN SERVICE	4,449	2,623	206,301		8.00	
9.00	00900	HOUSEKEEPING	20,659	12,181	0	1,033,035	9.00	
10.00	01000	DIETARY	27,277	16,083	17,327	11,558	10.00	
11.00	01100	CAFETERIA	47,806	28,187	0	20,256	11.00	
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	29,154	17,190	0	12,353	14.00	
15.00	01500	PHARMACY	28,210	16,633	0	11,953	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	32,724	19,294	0	13,866	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	162,762	95,967	47,122	68,964	30.00	
31.00	03100	INTENSIVE CARE UNIT	100,808	59,438	19,615	42,714	31.00	
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - I RF	103,412	60,973	16,077	43,817	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	42.00	
43.00	04300	NURSERY	57,484	33,893	0	24,357	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	271,252	159,935	13,666	114,932	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	242,044	142,712	20,951	102,557	54.00	
57.00	05700	CT SCAN	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00	
60.00	06000	LABORATORY	77,470	45,677	78	32,825	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01	
65.00	06500	RESPIRATORY THERAPY	36,402	21,463	0	15,424	65.00	
66.00	06600	PHYSICAL THERAPY	65,817	38,806	24,204	27,887	66.00	
69.01	06901	CARDIAC REHAB	32,355	19,077	576	13,709	69.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00	
91.00	09100	EMERGENCY	87,560	51,627	34,079	37,100	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
93.00	04040	CLINIC	165,399	0	0	79,713	93.00	
93.01	04044	BIC	230,597	0	0	97,707	93.01	
93.02	04041	UCIC	0	0	0	0	93.02	
93.03	04042	CIC	0	0	0	0	93.03	
93.04	04043	RIC	0	0	0	0	93.04	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00	
99.10	09910	CORF	0	0	0	0	99.10	
101.00	10100	HOME HEALTH AGENCY	28,623	0	8,973	12,128	101.00	
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00	
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00	
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00	
116.00	11600	HOSPICE	0	0	32	0	116.00	
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,852,264	841,759	202,700	783,820	306,728	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00	
191.00	19100	RESEARCH	0	0	0	0	191.00	
191.01	19101	FMH DIAGNOSTIC CENTER	0	0	0	0	191.01	
191.02	19102	WELLNESS	109,054	0	0	34,590	191.02	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	156,426	85,494	2,996	66,279	192.00	
192.01	19201	RFE	0	0	0	0	192.01	
192.02	19202	MARKETING	13,150	7,754	0	5,572	192.02	
192.03	19203	FOUNDATION	4,503	2,655	0	1,908	192.03	
192.04	19204	BROOKVILLE CLINIC	0	0	0	0	192.04	
192.05	19205	ATOD	0	0	0	0	192.05	
192.06	19206	HEART CENTER	10,232	6,033	0	4,335	192.06	
192.07	19207	WVCP	228,763	0	605	95,371	192.07	
192.08	19210	OCCUPATIONAL MED	0	0	0	0	192.08	
192.09	19209	HOME MEDICAL EQUIPMENT	0	0	0	0	192.09	
192.10	19211	HOSPITALIST	0	0	0	0	192.10	
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	164,053	0	0	41,160	194.00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150064

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

Worksheet B
Part I
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Cost Center Description		OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		7.00	7.01	8.00	9.00	10.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,538,445	943,695	206,301	1,033,035	498,903	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150064		Period: From 10/01/2011 To 09/30/2012		Worksheet B Part I Date/Time Prepared: 2/27/2013 7:31 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	568,011					11.00
13.00	01300	10,149	644,448				13.00
14.00	01400	4,259	0	1,337,705			14.00
15.00	01500	14,595	26,913	0	2,314,062		15.00
16.00	01600	28,099	0	0	0	1,562,331	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	47,584	79,917	0	0	72,669	30.00
31.00	03100	34,255	61,061	0	0	46,246	31.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	13,281	26,811	0	0	17,837	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	10,211	22,936	0	0	6,968	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	43,572	64,009	0	0	149,166	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	35,763	72,032	0	0	390,820	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	29,076	0	0	0	243,943	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	18,002	26,262	0	0	60,423	65.00
66.00	06600	17,399	39,119	0	0	32,314	66.00
69.01	06901	4,690	10,525	0	0	4,761	69.01
71.00	07100	0	0	1,337,705	0	50,057	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	2,314,062	119,658	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	29,684	66,718	0	0	170,927	91.00
92.00	09200						92.00
93.00	04040	64,307	0	0	0	96,557	93.00
93.01	04044	0	0	0	0	64,500	93.01
93.02	04041	0	0	0	0	0	93.02
93.03	04042	0	0	0	0	0	93.03
93.04	04043	0	0	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	24,817	55,747	0	0	17,892	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	27,004	50,673	0	0	13,793	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
116.00	11600	0	0	0	0	3,800	116.00
118.00		456,747	602,723	1,337,705	2,314,062	1,562,331	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
191.01	19101	3,147	0	0	0	0	191.01
191.02	19102	5,398	12,137	0	0	0	191.02
192.00	19200	35,020	16,594	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	1,177	0	0	0	0	192.02
192.03	19203	2,164	0	0	0	0	192.03
192.04	19204	0	0	0	0	0	192.04
192.05	19205	0	0	0	0	0	192.05
192.06	19206	0	0	0	0	0	192.06
192.07	19207	58,582	0	0	0	0	192.07
192.08	19210	0	0	0	0	0	192.08
192.09	19209	0	0	0	0	0	192.09
192.10	19211	5,776	12,994	0	0	0	192.10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150064

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

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	568,011	644,448	1,337,705	2,314,062	1,562,331	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150064

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

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Part I
Date/Time Prepared:
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
7.01	00701				7.01
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	2,900,912	0	2,900,912	30.00
31.00	03100	1,895,909	0	1,895,909	31.00
40.00	04000	0	0	0	40.00
41.00	04100	1,070,557	0	1,070,557	41.00
42.00	04200	0	0	0	42.00
43.00	04300	699,594	0	699,594	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	3,127,218	0	3,127,218	50.00
52.00	05200	0	0	0	52.00
54.00	05400	5,921,291	0	5,921,291	54.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	2,808,053	0	2,808,053	60.00
60.01	06001	0	0	0	60.01
65.00	06500	836,235	0	836,235	65.00
66.00	06600	1,398,850	0	1,398,850	66.00
69.01	06901	332,347	0	332,347	69.01
71.00	07100	1,387,762	0	1,387,762	71.00
72.00	07200	73,378	0	73,378	72.00
73.00	07300	2,433,720	0	2,433,720	73.00
74.00	07400	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
91.00	09100	2,235,668	0	2,235,668	91.00
92.00	09200	0	0	0	92.00
93.00	04040	2,996,021	0	2,996,021	93.00
93.01	04044	2,547,519	0	2,547,519	93.01
93.02	04041	0	0	0	93.02
93.03	04042	0	0	0	93.03
93.04	04043	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	1,019,693	0	1,019,693	95.00
99.10	09910	0	0	0	99.10
101.00	10100	1,401,373	0	1,401,373	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	0	0	0	109.00
110.00	11000	0	0	0	110.00
111.00	11100	0	0	0	111.00
116.00	11600	115,216	0	115,216	116.00
118.00		35,201,316	0	35,201,316	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
191.00	19100	0	0	0	191.00
191.01	19101	250,735	0	250,735	191.01
191.02	19102	445,112	0	445,112	191.02
192.00	19200	5,178,119	0	5,178,119	192.00
192.01	19201	3,684	0	3,684	192.01
192.02	19202	343,407	0	343,407	192.02
192.03	19203	13,526	0	13,526	192.03
192.04	19204	0	0	0	192.04
192.05	19205	0	0	0	192.05
192.06	19206	25,817	0	25,817	192.06
192.07	19207	3,410,498	0	3,410,498	192.07
192.08	19210	1,872	0	1,872	192.08

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150064

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

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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
192.09	19209	HOME MEDICAL EQUIPMENT	0	0	0	192.09
192.10	19211	HOSPITALIST	1,889,374	0	1,889,374	192.10
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	288,860	0	288,860	194.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	47,052,320	0	47,052,320	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150064

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS	0	7,545	7,545	7,545		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	157,679	157,679	482	158,161	5.00
7.00 00700	OPERATION OF PLANT	0	762,204	762,204	113	8,532	7.00
7.01 00701	OPERATION OF PLANT	0	0	0	0	3,172	7.01
8.00 00800	LAUNDRY & LINEN SERVICE	0	1,944	1,944	7	670	8.00
9.00 00900	HOUSEKEEPING	0	9,029	9,029	182	3,362	9.00
10.00 01000	DIETARY	0	11,922	11,922	59	1,434	10.00
11.00 01100	CAFETERIA	0	20,895	20,895	97	1,586	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	138	2,132	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	12,743	12,743	29	4,285	14.00
15.00 01500	PHARMACY	0	12,330	12,330	224	7,448	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	14,303	14,303	242	4,935	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	71,140	71,140	398	6,999	30.00
31.00 03100	INTENSIVE CARE UNIT	0	44,061	44,061	300	5,022	31.00
40.00 04000	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - I/RF	0	45,199	45,199	127	2,564	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	25,125	25,125	105	1,828	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	118,559	118,559	536	7,767	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	105,793	105,793	408	16,528	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	0	33,860	33,860	244	7,996	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	15,911	15,911	128	2,213	65.00
66.00 06600	PHYSICAL THERAPY	0	28,767	28,767	268	3,876	66.00
69.01 06901	CARDIAC REHAB	0	14,142	14,142	45	829	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	247	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 09100	EMERGENCY	0	38,271	38,271	355	5,909	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040	CLINIC	0	72,293	72,293	913	8,706	93.00
93.01 04044	BIC	0	0	0	323	7,242	93.01
93.02 04041	UCIC	0	0	0	0	0	93.02
93.03 04042	CIC	0	0	0	0	0	93.03
93.04 04043	RIC	0	0	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	0	0	171	3,096	95.00
99.10 09910	CORF	0	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	12,510	12,510	243	4,236	101.00
SPECIAL PURPOSE COST CENTERS							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
116.00 11600	HOSPICE	0	0	0	14	374	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,636,225	1,636,225	6,151	122,988	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
191.01 19101	FMH DIAGNOSTIC CENTER	0	0	0	52	832	191.01
191.02 19102	WELLNESS	0	0	0	29	954	191.02
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	64,904	64,904	684	16,185	192.00
192.01 19201	RFE	0	0	0	0	12	192.01
192.02 19202	MARKETING	0	5,748	5,748	8	1,061	192.02
192.03 19203	FOUNDATION	0	1,968	1,968	0	8	192.03
192.04 19204	BROOKVILLE CLINIC	0	0	0	0	0	192.04
192.05 19205	ATOD	0	0	0	0	0	192.05
192.06 19206	HEART CENTER	0	4,472	4,472	0	18	192.06
192.07 19207	WVCP	0	99,988	99,988	449	9,529	192.07

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150064

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

Worksheet B
Part II
Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
192.08 19210 OCCUPATIONAL MED	0	0	0	0	0	6	192.08
192.09 19209 HOME MEDICAL EQUIPMENT	0	0	0	0	0	0	192.09
192.10 19211 HOSPITALIST	0	0	0	0	172	6,287	192.10
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	71,705	71,705	71,705	0	281	194.00
200.00 Cross Foot Adjustments				0			200.00
201.00 Negative Cost Centers				0		0	201.00
202.00 TOTAL (sum lines 118-201)	0	1,885,010	1,885,010	1,885,010	7,545	158,161	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150064

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

Worksheet B
Part II
Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description		OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		7.00	7.01	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	770,849				7.00
7.01	00701	OPERATION OF PLANT	0	3,172			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,351	9	3,981		8.00
9.00	00900	HOUSEKEEPING	6,273	41	0	18,887	9.00
10.00	01000	DIETARY	8,283	54	334	211	10.00
11.00	01100	CAFETERIA	14,517	95	0	370	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,853	58	0	226	14.00
15.00	01500	PHARMACY	8,567	56	0	219	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,937	65	0	254	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	49,426	323	908	1,261	30.00
31.00	03100	INTENSIVE CARE UNIT	30,612	200	379	781	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	31,403	205	310	801	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	17,456	114	0	445	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	82,374	536	264	2,101	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	73,501	480	404	1,875	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	23,525	154	2	600	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	11,054	72	0	282	65.00
66.00	06600	PHYSICAL THERAPY	19,987	130	467	510	66.00
69.01	06901	CARDIAC REHAB	9,825	64	11	251	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100	EMERGENCY	26,589	174	658	678	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	CLINIC	50,227	0	0	1,457	93.00
93.01	04044	BIC	70,025	0	0	1,786	93.01
93.02	04041	UCIC	0	0	0	0	93.02
93.03	04042	CIC	0	0	0	0	93.03
93.04	04043	RIC	0	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	8,692	0	173	222	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
116.00	11600	HOSPICE	0	0	1	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	562,477	2,830	3,911	14,330	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
191.01	19101	FMH DIAGNOSTIC CENTER	0	0	0	0	191.01
191.02	19102	WELLNESS	33,116	0	0	632	191.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	47,502	287	58	1,212	192.00
192.01	19201	RFE	0	0	0	0	192.01
192.02	19202	MARKETING	3,993	26	0	102	192.02
192.03	19203	FOUNDATION	1,367	9	0	35	192.03
192.04	19204	BROOKVILLE CLINIC	0	0	0	0	192.04
192.05	19205	ATOD	0	0	0	0	192.05
192.06	19206	HEART CENTER	3,107	20	0	79	192.06
192.07	19207	WVCP	69,469	0	12	1,744	192.07
192.08	19210	OCCUPATIONAL MED	0	0	0	0	192.08
192.09	19209	HOME MEDICAL EQUIPMENT	0	0	0	0	192.09
192.10	19211	HOSPITALIST	0	0	0	0	192.10
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	49,818	0	0	753	194.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150064			Period: From 10/01/2011 To 09/30/2012		Worksheet B Part II Date/Time Prepared: 2/27/2013 7:31 pm	
Cost Center Description		OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		7.00	7.01	8.00	9.00	10.00		
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	770,849	3,172	3,981	18,887	22,297		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150064		Period: From 10/01/2011 To 09/30/2012		Worksheet B Part II Date/Time Prepared: 2/27/2013 7:31 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	37,560					11.00
13.00	01300	671	2,941				13.00
14.00	01400	282	0	26,476			14.00
15.00	01500	965	123	0	29,932		15.00
16.00	01600	1,858	0	0	0	31,594	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,147	365	0	0	1,468	30.00
31.00	03100	2,265	279	0	0	934	31.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	878	122	0	0	360	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	675	105	0	0	141	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,881	292	0	0	3,013	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	2,365	329	0	0	7,928	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	1,923	0	0	0	4,928	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	1,190	120	0	0	1,221	65.00
66.00	06600	1,151	179	0	0	653	66.00
69.01	06901	310	48	0	0	96	69.01
71.00	07100	0	0	26,476	0	1,011	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	29,932	2,417	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	1,963	304	0	0	3,453	91.00
92.00	09200						92.00
93.00	04040	4,251	0	0	0	1,951	93.00
93.01	04044	0	0	0	0	1,303	93.01
93.02	04041	0	0	0	0	0	93.02
93.03	04042	0	0	0	0	0	93.03
93.04	04043	0	0	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	1,641	254	0	0	361	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	1,786	231	0	0	279	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
116.00	11600	0	0	0	0	77	116.00
118.00		30,202	2,751	26,476	29,932	31,594	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
191.01	19101	208	0	0	0	0	191.01
191.02	19102	357	55	0	0	0	191.02
192.00	19200	2,316	76	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	78	0	0	0	0	192.02
192.03	19203	143	0	0	0	0	192.03
192.04	19204	0	0	0	0	0	192.04
192.05	19205	0	0	0	0	0	192.05
192.06	19206	0	0	0	0	0	192.06
192.07	19207	3,874	0	0	0	0	192.07
192.08	19210	0	0	0	0	0	192.08
192.09	19209	0	0	0	0	0	192.09
192.10	19211	382	59	0	0	0	192.10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150064

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

Worksheet B
Part II
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	37,560	2,941	26,476	29,932	31,594	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/27/2013 7:31 pm
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
7.01	00701				7.01
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	146,318	0	146,318	30.00
31.00	03100	86,522	0	86,522	31.00
40.00	04000	0	0	0	40.00
41.00	04100	83,105	0	83,105	41.00
42.00	04200	0	0	0	42.00
43.00	04300	45,994	0	45,994	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	218,323	0	218,323	50.00
52.00	05200	0	0	0	52.00
54.00	05400	209,611	0	209,611	54.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	73,232	0	73,232	60.00
60.01	06001	0	0	0	60.01
65.00	06500	32,191	0	32,191	65.00
66.00	06600	55,988	0	55,988	66.00
69.01	06901	25,621	0	25,621	69.01
71.00	07100	27,487	0	27,487	71.00
72.00	07200	247	0	247	72.00
73.00	07300	32,349	0	32,349	73.00
74.00	07400	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
91.00	09100	78,354	0	78,354	91.00
92.00	09200	0	0	0	92.00
93.00	04040	139,798	0	139,798	93.00
93.01	04044	80,679	0	80,679	93.01
93.02	04041	0	0	0	93.02
93.03	04042	0	0	0	93.03
93.04	04043	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	5,523	0	5,523	95.00
99.10	09910	0	0	0	99.10
101.00	10100	28,372	0	28,372	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	0	0	0	109.00
110.00	11000	0	0	0	110.00
111.00	11100	0	0	0	111.00
116.00	11600	466	0	466	116.00
118.00		1,370,180	0	1,370,180	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
191.00	19100	0	0	0	191.00
191.01	19101	1,092	0	1,092	191.01
191.02	19102	35,143	0	35,143	191.02
192.00	19200	133,224	0	133,224	192.00
192.01	19201	12	0	12	192.01
192.02	19202	11,016	0	11,016	192.02
192.03	19203	3,530	0	3,530	192.03
192.04	19204	0	0	0	192.04
192.05	19205	0	0	0	192.05
192.06	19206	7,696	0	7,696	192.06
192.07	19207	193,654	0	193,654	192.07
192.08	19210	6	0	6	192.08

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150064

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

Worksheet B
Part II
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
192.09	19209	HOME MEDICAL EQUIPMENT	0	0	0	192.09
192.10	19211	HOSPITALIST	6,900	0	6,900	192.10
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	122,557	0	122,557	194.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,885,010	0	1,885,010	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064

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

Worksheet B-1
Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00					
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	397,483					1.00
4.00 00400	EMPLOYEE BENEFITS	1,591	23,798,018				4.00
5.00 00500	ADMINISTRATIVE & GENERAL	33,249	1,519,560	-6,717,606	40,334,714		5.00
7.00 00700	OPERATION OF PLANT	160,722	357,739	0	2,176,033	233,956	7.00
7.01 00701	OPERATION OF PLANT	0	0	0	808,964	0	7.01
8.00 00800	LAUNDRY & LINEN SERVICE	410	22,069	0	170,785	410	8.00
9.00 00900	HOUSEKEEPING	1,904	574,310	0	857,398	1,904	9.00
10.00 01000	DIETARY	2,514	185,108	0	365,744	2,514	10.00
11.00 01100	CAFETERIA	4,406	306,898	0	404,409	4,406	11.00
13.00 01300	NURSING ADMINISTRATION	0	434,124	0	543,741	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,687	90,894	0	1,092,754	2,687	14.00
15.00 01500	PHARMACY	2,600	705,756	0	1,899,416	2,600	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,016	763,679	0	1,258,713	3,016	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	15,001	1,255,194	0	1,785,110	15,001	30.00
31.00 03100	INTENSIVE CARE UNIT	9,291	946,710	0	1,280,687	9,291	31.00
40.00 04000	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - I/RF	9,531	400,983	0	654,001	9,531	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	5,298	331,569	0	466,115	5,298	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	25,000	1,691,177	0	1,980,791	25,000	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	22,308	1,285,524	0	4,212,804	22,308	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	7,140	769,173	0	2,039,338	7,140	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	3,355	404,506	0	564,280	3,355	65.00
66.00 06600	PHYSICAL THERAPY	6,066	846,969	0	988,648	6,066	66.00
69.01 06901	CARDIAC REHAB	2,982	143,107	0	211,439	2,982	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	62,902	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 09100	EMERGENCY	8,070	1,121,365	0	1,506,989	8,070	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040	CLINIC	15,244	2,874,541	0	2,220,266	15,244	93.00
93.01 04044	BIC	0	1,019,293	0	1,847,088	21,253	93.01
93.02 04041	UCIC	0	0	0	0	0	93.02
93.03 04042	CIC	0	0	0	0	0	93.03
93.04 04043	RIC	0	0	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	539,069	0	789,713	0	95.00
99.10 09910	CORF	0	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	2,638	765,479	0	1,080,264	2,638	101.00
SPECIAL PURPOSE COST CENTERS							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
116.00 11600	HOSPICE	0	44,927	0	95,482	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	345,023	19,399,723	-6,717,606	31,363,874	170,714	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
191.01 19101	FMH DIAGNOSTIC CENTE	0	163,717	0	212,240	0	191.01
191.02 19102	WELLNESS	0	91,873	0	243,396	10,051	191.02
192.00 19200	PHYSICIANS' PRIVATE OFFICES	13,686	2,158,257	0	4,127,832	14,417	192.00
192.01 19201	RFE	0	0	0	3,158	0	192.01
192.02 19202	MARKETING	1,212	25,598	0	270,674	1,212	192.02
192.03 19203	FOUNDATION	415	0	0	1,968	415	192.03
192.04 19204	BROOKVILLE CLINIC	0	0	0	0	0	192.04
192.05 19205	ATOD	0	0	0	0	0	192.05
192.06 19206	HEART CENTER	943	0	0	4,472	943	192.06
192.07 19207	WVCP	21,084	1,415,976	0	2,430,251	21,084	192.07

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064

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

Worksheet B-1

Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00					
192.08 19210 OCCUPATIONAL MED	0	0	0	0	1,605	0	192.08
192.09 19209 HOME MEDICAL EQUIPMENT	0	0	0	0	0	0	192.09
192.10 19211 HOSPITALIST	0	542,874	0	0	1,603,539	0	192.10
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	15,120	0	0	0	71,705	15,120	194.00
200.00 Cross Foot Adjustments							200.00
201.00 Negative Cost Centers							201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1,885,010	5,594,032			6,717,606	2,538,445	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	4.742366	0.235063			0.166547	10.850096	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)		7,545			158,161	770,849	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)		0.000317			0.003921	3.294846	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064

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

Worksheet B-1

Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
		7.01	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
7.01	00701	147,513					7.01
8.00	00800		71,615				8.00
9.00	00900	1,904	0	224,704			9.00
10.00	01000	2,514	6,015	2,514	56,452		10.00
11.00	01100	4,406	0	4,406	0	774,495	11.00
13.00	01300	0	0	0	0	13,839	13.00
14.00	01400	2,687	0	2,687	0	5,807	14.00
15.00	01500	2,600	0	2,600	0	19,900	15.00
16.00	01600	3,016	0	3,016	0	38,314	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	15,001	16,358	15,001	27,554	64,882	30.00
31.00	03100	9,291	6,809	9,291	4,276	46,707	31.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	9,531	5,581	9,531	2,877	18,109	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	5,298	0	5,298	0	13,923	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	25,000	4,744	25,000	0	59,412	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	22,308	7,273	22,308	0	48,764	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	7,140	27	7,140	0	39,646	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	3,355	0	3,355	0	24,546	65.00
66.00	06600	6,066	8,402	6,066	0	23,724	66.00
69.01	06901	2,982	200	2,982	0	6,395	69.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	8,070	11,830	8,070	0	40,475	91.00
92.00	09200						92.00
93.00	04040	0	0	17,339	0	87,681	93.00
93.01	04044	0	0	21,253	0	0	93.01
93.02	04041	0	0	0	0	0	93.02
93.03	04042	0	0	0	0	0	93.03
93.04	04043	0	0	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	33,838	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	3,115	2,638	0	36,821	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
116.00	11600	0	11	0	0	0	116.00
118.00		131,579	70,365	170,495	34,707	622,783	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
191.01	19101	0	0	0	0	4,291	191.01
191.02	19102	0	0	7,524	0	7,360	191.02
192.00	19200	13,364	1,040	14,417	0	47,751	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	1,212	0	1,212	0	1,605	192.02
192.03	19203	415	0	415	0	2,951	192.03
192.04	19204	0	0	0	0	0	192.04
192.05	19205	0	0	0	0	0	192.05
192.06	19206	943	0	943	0	0	192.06
192.07	19207	0	210	20,745	21,745	79,878	192.07
192.08	19210	0	0	0	0	0	192.08
192.09	19209	0	0	0	0	0	192.09

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064

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

Worksheet B-1

Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
		7.01	8.00	9.00	10.00	11.00	
192.10	19211 HOSPITALIST	0	0	0	0	7,876	192.10
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	8,953	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	943,695	206,301	1,033,035	498,903	568,011	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6.397368	2.880695	4.597315	8.837650	0.733395	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	3,172	3,981	18,887	22,297	37,560	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.021503	0.055589	0.084053	0.394973	0.048496	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064

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

Worksheet B-1
Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description		NURSING ADMINISTRATION (FTE'S)	CENTRAL SERVICES & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
7.01	00701					7.01
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	18,797				13.00
14.00	01400	0	100			14.00
15.00	01500	785	0	100		15.00
16.00	01600	0	0	0	102,466,518	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	2,331	0	0	4,766,135	30.00
31.00	03100	1,781	0	0	3,033,114	31.00
40.00	04000	0	0	0	0	40.00
41.00	04100	782	0	0	1,169,849	41.00
42.00	04200	0	0	0	0	42.00
43.00	04300	669	0	0	456,988	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	1,867	0	0	9,783,332	50.00
52.00	05200	0	0	0	0	52.00
54.00	05400	2,101	0	0	25,631,069	54.00
57.00	05700	0	0	0	0	57.00
58.00	05800	0	0	0	0	58.00
59.00	05900	0	0	0	0	59.00
60.00	06000	0	0	0	15,999,409	60.00
60.01	06001	0	0	0	0	60.01
65.00	06500	766	0	0	3,962,933	65.00
66.00	06600	1,141	0	0	2,119,353	66.00
69.01	06901	307	0	0	312,246	69.01
71.00	07100	0	100	0	3,283,049	71.00
72.00	07200	0	0	0	0	72.00
73.00	07300	0	0	100	7,847,996	73.00
74.00	07400	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	0	0	0	0	88.00
89.00	08900	0	0	0	0	89.00
91.00	09100	1,946	0	0	11,210,538	91.00
92.00	09200	0	0	0	0	92.00
93.00	04040	0	0	0	6,332,839	93.00
93.01	04044	0	0	0	4,230,330	93.01
93.02	04041	0	0	0	0	93.02
93.03	04042	0	0	0	0	93.03
93.04	04043	0	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	1,626	0	0	1,173,482	95.00
99.10	09910	0	0	0	0	99.10
101.00	10100	1,478	0	0	904,631	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900	0	0	0	0	109.00
110.00	11000	0	0	0	0	110.00
111.00	11100	0	0	0	0	111.00
116.00	11600	0	0	0	249,225	116.00
118.00		17,580	100	100	102,466,518	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
191.00	19100	0	0	0	0	191.00
191.01	19101	0	0	0	0	191.01
191.02	19102	354	0	0	0	191.02
192.00	19200	484	0	0	0	192.00
192.01	19201	0	0	0	0	192.01
192.02	19202	0	0	0	0	192.02
192.03	19203	0	0	0	0	192.03
192.04	19204	0	0	0	0	192.04
192.05	19205	0	0	0	0	192.05
192.06	19206	0	0	0	0	192.06
192.07	19207	0	0	0	0	192.07
192.08	19210	0	0	0	0	192.08

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064

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

Worksheet B-1

Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description		NURSING ADMINISTRATION (FTE'S)	CENTRAL SERVICES & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		13.00	14.00	15.00	16.00	
192.09	19209 HOME MEDICAL EQUIPMENT	0	0	0	0	192.09
192.10	19211 HOSPITALIST	379	0	0	0	192.10
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	644,448	1,337,705	2,314,062	1,562,331	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	34.284620	13,377.050000	23,140.620000	0.015247	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	2,941	26,476	29,932	31,594	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.156461	264.760000	299.320000	0.000308	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150064

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

Worksheet C
Part I
Date/Time Prepared:
2/27/2013 7:31 pm

		Title XVIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		2,900,912	0	2,900,912	30.00
31.00	03100	INTENSIVE CARE UNIT		1,895,909	0	1,895,909	31.00
40.00	04000	SUBPROVIDER - I/PF		0	0	0	40.00
41.00	04100	SUBPROVIDER - I/RF		1,070,557	0	1,070,557	41.00
42.00	04200	SUBPROVIDER		0	0	0	42.00
43.00	04300	NURSERY		699,594	0	699,594	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		3,127,218	126,050	3,253,268	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		5,921,291	0	5,921,291	54.00
57.00	05700	CT SCAN		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000	LABORATORY		2,808,053	0	2,808,053	60.00
60.01	06001	BLOOD LABORATORY		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	836,235	0	836,235	65.00
66.00	06600	PHYSICAL THERAPY	0	1,398,850	0	1,398,850	66.00
69.01	06901	CARDIAC REHAB		332,347	0	332,347	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,387,762	0	1,387,762	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		73,378	0	73,378	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		2,433,720	0	2,433,720	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
91.00	09100	EMERGENCY		2,235,668	0	2,235,668	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		562,216	0	562,216	92.00
93.00	04040	CLINIC		2,996,021	0	2,996,021	93.00
93.01	04044	BIC		2,547,519	58,021	2,605,540	93.01
93.02	04041	UCIC		0	0	0	93.02
93.03	04042	CIC		0	0	0	93.03
93.04	04043	RIC		0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES		1,019,693	0	1,019,693	95.00
99.10	09910	CORF		0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY		1,401,373	0	1,401,373	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION		0	0	0	110.00
111.00	11100	ISLET ACQUISITION		0	0	0	111.00
116.00	11600	HOSPICE		115,216	0	115,216	116.00
200.00		Subtotal (see instructions)	0	35,763,532	184,071	35,947,603	200.00
201.00		Less Observation Beds		562,216	0	562,216	201.00
202.00		Total (see instructions)	0	35,201,316	184,071	35,385,387	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150064		Period: From 10/01/2011 To 09/30/2012		Worksheet C Part I Date/Time Prepared: 2/27/2013 7:31 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,303,409		4,303,409			30.00
31.00	03100	INTENSIVE CARE UNIT	2,807,750		2,807,750			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	1,169,849		1,169,849			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	456,988		456,988			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,596,484	7,290,035	8,886,519	0.351906	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,366,152	23,150,739	25,516,891	0.232054	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	3,529,635	11,872,123	15,401,758	0.182320	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	1,693,391	1,934,083	3,627,474	0.230528	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	832,677	1,286,676	2,119,353	0.660036	0.000000	66.00
69.01	06901	CARDIAC REHAB	0	312,043	312,043	1.065068	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,286,137	1,815,391	3,101,528	0.447445	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,981	133,540	181,521	0.404240	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,663,519	4,184,477	7,847,996	0.310107	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
91.00	09100	EMERGENCY	1,735,256	9,451,270	11,186,526	0.199854	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	688,090	688,090	0.817068	0.000000	92.00
93.00	04040	CLINIC	0	3,116,546	3,116,546	0.961327	0.000000	93.00
93.01	04044	BIC	0	3,806,221	3,806,221	0.669304	0.000000	93.01
93.02	04041	UCIC	0	0	0	0.000000	0.000000	93.02
93.03	04042	CIC	0	0	0	0.000000	0.000000	93.03
93.04	04043	RIC	0	0	0	0.000000	0.000000	93.04
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	1,173,482	1,173,482	0.868946	0.000000	95.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	904,631	904,631			101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
116.00	11600	HOSPICE	0	249,225	249,225			116.00
200.00		Subtotal (see instructions)	25,489,228	71,368,572	96,857,800			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	25,489,228	71,368,572	96,857,800			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/27/2013 7:31 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - I PF			40.00
41.00	04100 SUBPROVIDER - I RF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.366090		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.232054		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.182320		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.230528		65.00
66.00	06600 PHYSICAL THERAPY	0.660036		66.00
69.01	06901 CARDIAC REHAB	1.065068		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.447445		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.404240		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.310107		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
91.00	09100 EMERGENCY	0.199854		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.817068		92.00
93.00	04040 CLINIC	0.961327		93.00
93.01	04044 BIC	0.684548		93.01
93.02	04041 UCIC	0.000000		93.02
93.03	04042 CIC	0.000000		93.03
93.04	04043 RIC	0.000000		93.04
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.868946		95.00
99.10	09910 CORF			99.10
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/27/2013 7:31 pm
		Title XIX	Hospital	Cost

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		2,900,912	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT		1,895,909	0	0	31.00
40.00	04000 SUBPROVIDER - I/PF		0	0	0	40.00
41.00	04100 SUBPROVIDER - I/RF		1,070,557	0	0	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
43.00	04300 NURSERY		699,594	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		3,127,218	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,921,291	0	0	54.00
57.00	05700 CT SCAN		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		2,808,053	0	0	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	836,235	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	1,398,850	0	0	66.00
69.01	06901 CARDIAC REHAB		332,347	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1,387,762	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		73,378	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		2,433,720	0	0	73.00
74.00	07400 RENAL DIALYSIS		0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
91.00	09100 EMERGENCY		2,235,668	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		562,216	0	0	92.00
93.00	04040 CLINIC		2,996,021	0	0	93.00
93.01	04044 BIC		2,547,519	0	0	93.01
93.02	04041 UCIC		0	0	0	93.02
93.03	04042 CIC		0	0	0	93.03
93.04	04043 RIC		0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		1,019,693	0	0	95.00
99.10	09910 CORF		0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY		1,401,373	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION		0	0	0	110.00
111.00	11100 ISLET ACQUISITION		0	0	0	111.00
116.00	11600 HOSPICE		115,216	0	0	116.00
200.00	Subtotal (see instructions)	0	35,763,532	0	0	200.00
201.00	Less Observation Beds		562,216	0	0	201.00
202.00	Total (see instructions)	0	35,201,316	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150064

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

Worksheet C
Part I
Date/Time Prepared:
2/27/2013 7:31 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,303,409		4,303,409		30.00
31.00	03100	INTENSIVE CARE UNIT	2,807,750		2,807,750		31.00
40.00	04000	SUBPROVIDER - IPF	0		0		40.00
41.00	04100	SUBPROVIDER - IRF	1,169,849		1,169,849		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	456,988		456,988		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,596,484	7,290,035	8,886,519	0.351906	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,366,152	23,150,739	25,516,891	0.232054	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	3,529,635	11,872,123	15,401,758	0.182320	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	1,693,391	1,934,083	3,627,474	0.230528	65.00
66.00	06600	PHYSICAL THERAPY	832,677	1,286,676	2,119,353	0.660036	66.00
69.01	06901	CARDIAC REHAB	0	312,043	312,043	1.065068	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,286,137	1,815,391	3,101,528	0.447445	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,981	133,540	181,521	0.404240	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,663,519	4,184,477	7,847,996	0.310107	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
91.00	09100	EMERGENCY	1,735,256	9,451,270	11,186,526	0.199854	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	688,090	688,090	0.817068	92.00
93.00	04040	CLINIC	0	3,116,546	3,116,546	0.961327	93.00
93.01	04044	BIC	0	3,806,221	3,806,221	0.669304	93.01
93.02	04041	UCIC	0	0	0	0.000000	93.02
93.03	04042	CIC	0	0	0	0.000000	93.03
93.04	04043	RIC	0	0	0	0.000000	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	1,173,482	1,173,482	0.868946	95.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	904,631	904,631		101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
116.00	11600	HOSPICE	0	249,225	249,225		116.00
200.00		Subtotal (see instructions)	25,489,228	71,368,572	96,857,800		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	25,489,228	71,368,572	96,857,800		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/27/2013 7:31 pm
Cost Center Description		PPS Inpatient Ratio 11.00	Title XIX	Hospital Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.01	06901 CARDIAC REHAB	0.000000		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040 CLINIC	0.000000		93.00
93.01	04044 BIC	0.000000		93.01
93.02	04041 UCIC	0.000000		93.02
93.03	04042 CIC	0.000000		93.03
93.04	04043 RIC	0.000000		93.04
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
99.10	09910 CORF			99.10
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150064		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part I Date/Time Prepared: 2/27/2013 7:31 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	146,318	1,114	145,204	2,975	48.81	30.00
31.00	03100 INTENSIVE CARE UNIT	86,522		86,522	1,599	54.11	31.00
40.00	04000 SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	04100 SUBPROVIDER - IRF	83,105	0	83,105	966	86.03	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	04300 NURSERY	45,994		45,994	473	97.24	43.00
200.00	Total (lines 30-199)	361,939		360,825	6,013		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part I Date/Time Prepared: 2/27/2013 7:31 pm
		Title XVIII	Hospital	PPS

Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	1,368	66,772	30.00
31.00	03100 INTENSIVE CARE UNIT	883	47,779	31.00
40.00	04000 SUBPROVIDER - IPF	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	760	65,383	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	0	0	43.00
200.00	Total (lines 30-199)	3,011	179,934	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150064

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

Worksheet D
Part II
Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	218,323	8,886,519	0.024568	517,466	12,713	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	209,611	25,516,891	0.008215	1,981,977	16,282	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	73,232	15,401,758	0.004755	2,535,637	12,057	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	32,191	3,627,474	0.008874	1,211,309	10,749	65.00
66.00	06600 PHYSICAL THERAPY	55,988	2,119,353	0.026417	92,314	2,439	66.00
69.01	06901 CARDIAC REHAB	25,621	312,043	0.082107	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	27,487	3,101,528	0.008862	586,663	5,199	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	247	181,521	0.001361	32,645	44	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	32,349	7,847,996	0.004122	1,892,337	7,800	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100 EMERGENCY	78,354	11,186,526	0.007004	1,102,303	7,721	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	28,575	688,090	0.041528	0	0	92.00
93.00	04040 CLINIC	139,798	3,116,546	0.044857	0	0	93.00
93.01	04044 BIC	80,679	3,806,221	0.021197	0	0	93.01
93.02	04041 UIC	0	0	0.000000	0	0	93.02
93.03	04042 CIC	0	0	0.000000	0	0	93.03
93.04	04043 RIC	0	0	0.000000	0	0	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,002,455	85,792,466		9,952,651	75,004	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150064		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/27/2013 7:31 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150064		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/27/2013 7:31 pm	
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PPS	
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,975	0.00	1,368	0	30.00	
31.00	03100 INTENSIVE CARE UNIT	1,599	0.00	883	0	31.00	
40.00	04000 SUBPROVIDER - IPF	0	0.00	0	0	40.00	
41.00	04100 SUBPROVIDER - IRF	966	0.00	760	0	41.00	
42.00	04200 SUBPROVIDER	0	0.00	0	0	42.00	
43.00	04300 NURSERY	473	0.00	0	0	43.00	
200.00	Total (lines 30-199)	6,013		3,011	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/27/2013 7:31 pm
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Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
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
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	CLINIC	0	0	0	0	0	93.00
93.01	04044	BIC	0	0	0	0	0	93.01
93.02	04041	UCIC	0	0	0	0	0	93.02
93.03	04042	CIC	0	0	0	0	0	93.03
93.04	04043	RIC	0	0	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
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: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/27/2013 7:31 pm
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Cost Center Description		Title XVIII			Hospital		PPS
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	8,886,519	0.000000	0.000000	517,466	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	25,516,891	0.000000	0.000000	1,981,977	54.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	15,401,758	0.000000	0.000000	2,535,637	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	3,627,474	0.000000	0.000000	1,211,309	65.00
66.00	06600 PHYSICAL THERAPY	0	2,119,353	0.000000	0.000000	92,314	66.00
69.01	06901 CARDIAC REHAB	0	312,043	0.000000	0.000000	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,101,528	0.000000	0.000000	586,663	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	181,521	0.000000	0.000000	32,645	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7,847,996	0.000000	0.000000	1,892,337	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100 EMERGENCY	0	11,186,526	0.000000	0.000000	1,102,303	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	688,090	0.000000	0.000000	0	92.00
93.00	04040 CLINIC	0	3,116,546	0.000000	0.000000	0	93.00
93.01	04044 BIC	0	3,806,221	0.000000	0.000000	0	93.01
93.02	04041 UCIC	0	0	0.000000	0.000000	0	93.02
93.03	04042 CIC	0	0	0.000000	0.000000	0	93.03
93.04	04043 RIC	0	0	0.000000	0.000000	0	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	85,792,466			9,952,651	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/27/2013 7:31 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	PPS
Title XVIII						
ANCILLARY SERVICE COST CENTERS		11.00	12.00	13.00		
50.00	05000 OPERATING ROOM	0	2,041,471	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	8,952,522	0		54.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	383,061	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
65.00	06500 RESPIRATORY THERAPY	0	1,016,652	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
69.01	06901 CARDIAC REHAB	0	0	0		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	521,140	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,710,662	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100 EMERGENCY	0	2,099,588	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	378,586	0		92.00
93.00	04040 CLINIC	0	623,540	0		93.00
93.01	04044 BIC	0	438,344	0		93.01
93.02	04041 UCIC	0	0	0		93.02
93.03	04042 CIC	0	0	0		93.03
93.04	04043 RIC	0	0	0		93.04
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	18,165,566	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/27/2013 7:31 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.351906	2,041,471	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.232054	8,952,522	57	20,908	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000 LABORATORY	0.182320	383,061	9	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.230528	1,016,652	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.660036	0	0	0	66.00
69.01	06901 CARDIAC REHAB	1.065068	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.447445	521,140	0	69	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.404240	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.310107	1,710,662	41	14,963	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
91.00	09100 EMERGENCY	0.199854	2,099,588	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.817068	378,586	0	0	92.00
93.00	04040 CLINIC	0.961327	623,540	5	935	93.00
93.01	04044 BIC	0.669304	438,344	1	66	93.01
93.02	04041 UCIC	0.000000	0	0	0	93.02
93.03	04042 CIC	0.000000	0	0	0	93.03
93.04	04043 RIC	0.000000	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.868946		0		95.00
200.00	Subtotal (see instructions)		18,165,566	113	36,941	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		18,165,566	113	36,941	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/27/2013 7:31 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			Hospital	PPS	
	PPS Services (see inst.)	Cost	Cost			
		Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
5.00	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	718,406	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,077,469	13	4,852	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	69,840	2	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	234,367	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
69.01	06901	CARDIAC REHAB	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	233,181	0	31	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	530,488	13	4,640	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	09100	EMERGENCY	419,611	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	309,331	0	0	92.00
93.00	04040	CLINIC	599,426	5	899	93.00
93.01	04044	BIC	293,385	1	44	93.01
93.02	04041	UCIC	0	0	0	93.02
93.03	04042	CIC	0	0	0	93.03
93.04	04043	RIC	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		0		95.00
200.00		Subtotal (see instructions)	5,485,504	34	10,466	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	5,485,504	34	10,466	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150064 Component CCN: 15T064		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part II Date/Time Prepared: 2/27/2013 7:31 pm		
		Title XVIIII		Subprovider - IRF		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	218,323	8,886,519	0.024568	3,291	81	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	209,611	25,516,891	0.008215	33,623	276	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	73,232	15,401,758	0.004755	51,115	243	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	32,191	3,627,474	0.008874	33,211	295	65.00
66.00	06600	PHYSICAL THERAPY	55,988	2,119,353	0.026417	532,257	14,061	66.00
69.01	06901	CARDIAC REHAB	25,621	312,043	0.082107	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,487	3,101,528	0.008862	17,239	153	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	247	181,521	0.001361	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,349	7,847,996	0.004122	136,819	564	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	78,354	11,186,526	0.007004	3,291	23	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	688,090	0.000000	0	0	92.00
93.00	04040	CLINIC	139,798	3,116,546	0.044857	0	0	93.00
93.01	04044	BIC	80,679	3,806,221	0.021197	0	0	93.01
93.02	04041	UCIC	0	0	0.000000	0	0	93.02
93.03	04042	CIC	0	0	0.000000	0	0	93.03
93.04	04043	RIC	0	0	0.000000	0	0	93.04
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	973,880	85,792,466		810,846	15,696	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150064 Component CCN: 15T064	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/27/2013 7:31 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	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
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
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
69.01	06901 CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 CLINIC	0	0	0	0	0	93.00
93.01	04044 BIC	0	0	0	0	0	93.01
93.02	04041 UCIC	0	0	0	0	0	93.02
93.03	04042 CIC	0	0	0	0	0	93.03
93.04	04043 RIC	0	0	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
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: 150064 Component CCN: 15T064	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/27/2013 7:31 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	8,886,519	0.000000	0.000000	3,291	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	25,516,891	0.000000	0.000000	33,623	54.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	15,401,758	0.000000	0.000000	51,115	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	3,627,474	0.000000	0.000000	33,211	65.00
66.00	06600 PHYSICAL THERAPY	0	2,119,353	0.000000	0.000000	532,257	66.00
69.01	06901 CARDIAC REHAB	0	312,043	0.000000	0.000000	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,101,528	0.000000	0.000000	17,239	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	181,521	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7,847,996	0.000000	0.000000	136,819	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100 EMERGENCY	0	11,186,526	0.000000	0.000000	3,291	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	688,090	0.000000	0.000000	0	92.00
93.00	04040 CLINIC	0	3,116,546	0.000000	0.000000	0	93.00
93.01	04044 BIC	0	3,806,221	0.000000	0.000000	0	93.01
93.02	04041 UCI C	0	0	0.000000	0.000000	0	93.02
93.03	04042 CIC	0	0	0.000000	0.000000	0	93.03
93.04	04043 RIC	0	0	0.000000	0.000000	0	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	85,792,466			810,846	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150064 Component CCN: 15T064	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/27/2013 7:31 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.01	06901 CARDIAC REHAB	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040 CLINIC	0	0	0	93.00
93.01	04044 BIC	0	0	0	93.01
93.02	04041 UCIC	0	0	0	93.02
93.03	04042 CIC	0	0	0	93.03
93.04	04043 RIC	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 2/27/2013 7:31 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,093	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,975	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,394	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		30	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)		88	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,368	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		26	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)		79	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		184.15	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		188.27	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)		2,900,912	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)		5,524	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)		16,568	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)		22,092	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,878,820	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		6,912,738	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		6,912,738	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.416451	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		2,887.53	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)		2,878,820	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)		967.67	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,323,773	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,323,773	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/27/2013 7:31 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
Title XVIII		1.00	2.00	3.00	4.00	5.00	
Hospital							
PPS							
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,895,909	1,599	1,185.68	883	1,046,955	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)					2,534,656	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,905,384	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					114,551	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					75,004	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					189,555	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,715,829	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)					4,788	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					14,873	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					19,661	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)					581	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					967.67	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					562,216	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/27/2013 7:31 pm	
Title XVIII		Hospital		PPS			
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	146,318	2,878,820	0.050826	562,216	28,575	90.00
91.00	Nursing School cost	0	2,878,820	0.000000	562,216	0	91.00
92.00	Allied health cost	0	2,878,820	0.000000	562,216	0	92.00
93.00	All other Medical Education	0	2,878,820	0.000000	562,216	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1
		Component CCN: 15T064		Date/Time Prepared: 2/27/2013 7:31 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		966	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		966	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)		966	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)		760	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,070,557	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)		1,070,557	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,169,849	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,169,849	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.915124	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)		1,211.02	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)		1,070,557	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)		1,108.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		842,262	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)		842,262	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1	
		Component CCN: 15T064				Date/Time Prepared: 2/27/2013 7:31 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					428,092		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,270,354		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)					65,383		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					15,696		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					81,079		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,189,275		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064 Component CCN: 15T064		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/27/2013 7:31 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	83,105	1,070,557	0.077628	0	0	90.00
91.00	Nursing School cost	0	1,070,557	0.000000	0	0	91.00
92.00	Allied health cost	0	1,070,557	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,070,557	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 2/27/2013 7:31 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,093	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,975	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,394	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)		118	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)		198	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)		473	15.00
16.00	Nursery days (title V or XIX only)		39	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		184.15	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		188.27	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)		2,900,912	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)		22,216	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)		22,216	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,878,696	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		6,912,738	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		6,912,738	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.416434	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		2,887.53	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)		2,878,696	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)		967.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		191,591	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)		191,591	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1 Date/Time Prepared: 2/27/2013 7:31 pm		
Cost Center Description			Title XIX	Hospital	Cost		
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	NURSERY (title V & XIX only)	699,594	473	1,479.06	39	57,683	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,895,909	1,599	1,185.68	131	155,324	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)					249,042	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					653,640	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)					581	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					967.63	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					562,193	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/27/2013 7:31 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1
		Component CCN: 15T064		Date/Time Prepared: 2/27/2013 7:31 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		966	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		966	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)		966	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		20	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)		473	15.00
16.00	Nursery days (title V or XIX only)		39	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,070,557	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)		1,070,557	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,169,849	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,169,849	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.915124	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)		1,211.02	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)		1,070,557	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)		1,108.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		22,165	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		22,165	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1	
		Component CCN: 15T064				Date/Time Prepared: 2/27/2013 7:31 pm	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					22,165		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)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064 Component CCN: 15T064		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/27/2013 7:31 pm	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/27/2013 7:31 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,705,535	30.00
31.00	03100	INTENSIVE CARE UNIT		1,872,971	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		6,469	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.366090	517,466	189,439 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232054	1,981,977	459,926 54.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.182320	2,535,637	462,297 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0.230528	1,211,309	279,241 65.00
66.00	06600	PHYSICAL THERAPY	0.660036	92,314	60,931 66.00
69.01	06901	CARDIAC REHAB	1.065068	0	0 69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.447445	586,663	262,499 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.404240	32,645	13,196 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.310107	1,892,337	586,827 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0 74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
91.00	09100	EMERGENCY	0.199854	1,102,303	220,300 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.817068	0	0 92.00
93.00	04040	CLINIC	0.961327	0	0 93.00
93.01	04044	BIC	0.684548	0	0 93.01
93.02	04041	UCIC	0.000000	0	0 93.02
93.03	04042	CIC	0.000000	0	0 93.03
93.04	04043	RIC	0.000000	0	0 93.04
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			
200.00		Total (sum of lines 50-94 and 96-98)		9,952,651	2,534,656 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		9,952,651	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150064 Component CCN: 15T064	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/27/2013 7:31 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		901,604	41.00
42.00	04200 SUBPROVIDER		0	42.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.366090	3,291	1,205 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0 52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.232054	33,623	7,802 54.00
57.00	05700 CT SCAN	0.000000	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000 LABORATORY	0.182320	51,115	9,319 60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0 60.01
65.00	06500 RESPIRATORY THERAPY	0.230528	33,211	7,656 65.00
66.00	06600 PHYSICAL THERAPY	0.660036	532,257	351,309 66.00
69.01	06901 CARDIAC REHAB	1.065068	0	0 69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.447445	17,239	7,714 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.404240	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.310107	136,819	42,429 73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0 74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		0 88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
91.00	09100 EMERGENCY	0.199854	3,291	658 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.817068	0	0 92.00
93.00	04040 CLINIC	0.961327	0	0 93.00
93.01	04044 BIC	0.684548	0	0 93.01
93.02	04041 UCIC	0.000000	0	0 93.02
93.03	04042 CIC	0.000000	0	0 93.03
93.04	04043 RIC	0.000000	0	0 93.04
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			
200.00	Total (sum of lines 50-94 and 96-98)		810,846	428,092 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net Charges (line 200 minus line 201)		810,846	428,092 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150064 Component CCN: 15U064	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/27/2013 7:31 pm
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		280	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		0	41.00
42.00	04200 SUBPROVIDER		0	42.00
43.00	04300 NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.351906	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.232054	2,251	522 54.00
57.00	05700 CT SCAN	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000 LABORATORY	0.182320	14,926	2,721 60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.230528	21,394	4,932 65.00
66.00	06600 PHYSICAL THERAPY	0.660036	34,868	23,014 66.00
69.01	06901 CARDIAC REHAB	1.065068	0	0 69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.447445	7,121	3,186 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.404240	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.310107	41,744	12,945 73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0 74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0 88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0 89.00
91.00	09100 EMERGENCY	0.199854	509	102 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.817068	0	0 92.00
93.00	04040 CLINIC	0.961327	0	0 93.00
93.01	04044 BIC	0.669304	0	0 93.01
93.02	04041 UCIC	0.000000	0	0 93.02
93.03	04042 CIC	0.000000	0	0 93.03
93.04	04043 RIC	0.000000	0	0 93.04
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			
200.00	Total (sum of lines 50-94 and 96-98)		122,813	47,422 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net Charges (line 200 minus line 201)		122,813	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/27/2013 7:31 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		273,631	30.00
31.00	03100	INTENSIVE CARE UNIT		86,565	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		96,974	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.351906	153,542	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232054	82,268	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.182320	240,699	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.230528	51,431	65.00
66.00	06600	PHYSICAL THERAPY	0.660036	7,844	66.00
69.01	06901	CARDIAC REHAB	1.065068	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.447445	91,063	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.404240	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.310107	196,101	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
91.00	09100	EMERGENCY	0.199854	67,270	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.817068	0	92.00
93.00	04040	CLINIC	0.961327	0	93.00
93.01	04044	BIC	0.669304	0	93.01
93.02	04041	UCIC	0.000000	0	93.02
93.03	04042	CIC	0.000000	0	93.03
93.04	04043	RIC	0.000000	0	93.04
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		890,218	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)		890,218	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150064 Component CCN: 15T064	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/27/2013 7:31 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		45,272	41.00
42.00	04200 SUBPROVIDER		0	42.00
43.00	04300 NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.351906	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.232054	0	54.00
57.00	05700 CT SCAN	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000 LABORATORY	0.182320	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.230528	0	65.00
66.00	06600 PHYSICAL THERAPY	0.660036	0	66.00
69.01	06901 CARDIAC REHAB	1.065068	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.447445	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.404240	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.310107	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
91.00	09100 EMERGENCY	0.199854	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.817068	0	92.00
93.00	04040 CLINIC	0.961327	0	93.00
93.01	04044 BIC	0.669304	0	93.01
93.02	04041 UCIC	0.000000	0	93.02
93.03	04042 CIC	0.000000	0	93.03
93.04	04043 RIC	0.000000	0	93.04
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (sum of lines 50-94 and 96-98)		0	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)		0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3	
		Component CCN: 15U064		Date/Time Prepared: 2/27/2013 7:31 pm	
Cost Center Description		Title XIX	Swing Beds - SNF	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.351906	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232054	0	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.182320	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.230528	0	65.00
66.00	06600	PHYSICAL THERAPY	0.660036	0	66.00
69.01	06901	CARDIAC REHAB	1.065068	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.447445	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.404240	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.310107	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
91.00	09100	EMERGENCY	0.199854	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.817068	0	92.00
93.00	04040	CLINIC	0.961327	0	93.00
93.01	04044	BIC	0.669304	0	93.01
93.02	04041	UCIC	0.000000	0	93.02
93.03	04042	CIC	0.000000	0	93.03
93.04	04043	RIC	0.000000	0	93.04
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		0	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)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part A Date/Time Prepared: 2/27/2013 7:31 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		4,586,636	1.00
2.00	Outlier payments for discharges. (see instructions)		14,777	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		63.09	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.74	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		28.29	31.00
32.00	Sum of lines 30 and 31		34.03	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00
34.00	Disproportionate share adjustment (see instructions)		550,396	34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		5,151,809	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part A Date/Time Prepared: 2/27/2013 7:31 pm
		Title XVIII	Hospital	PPS
		before 1/1	on/after 1/1	
		1.00	1.01	
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	5,151,809		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	369,462		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)	0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).	0		52.00
53.00	Nursing and Allied Health Managed Care payment	0		53.00
54.00	Special add-on payments for new technologies	0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)	0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)	0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).	0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	0		58.00
59.00	Total (sum of amounts on lines 49 through 58)	5,521,271		59.00
60.00	Primary payer payments	21,678		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	5,499,593		61.00
62.00	Deductibles billed to program beneficiaries	618,688		62.00
63.00	Coinsurance billed to program beneficiaries	2,872		63.00
64.00	Allowable bad debts (see instructions)	79,767		64.00
65.00	Adjusted reimbursable bad debts (see instructions)	55,837		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	-6,486		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	4,933,870		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)	0		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)	0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		70.00
70.95	Recovery of Accelerated Depreciation	0		70.95
70.96	Low Volume Payment-1	0		70.96
70.97	Low Volume Payment-2	512,689		70.97
70.98	Low Volume Payment-3	0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	5,446,559		71.00
72.00	Interim payments	5,609,628		72.00
73.00	Tentative settlement (for contractor use only)	0		73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)	-163,069		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2	50,000		75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)	0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2	0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)	0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)	0		93.00
94.00	The rate used to calculate the Time Value of Money	0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)	0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)	0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/27/2013 7:31 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			10,500 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			5,485,504 2.00
3.00	PPS payments			4,633,319 3.00
4.00	Outlier payment (see instructions)			727 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.761 5.00
6.00	Line 2 times line 5			4,174,469 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)			10,500 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			37,054 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)			37,054 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			37,054 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			26,554 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)			10,500 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)			4,634,046 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,130,409 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)			3,514,137 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)			3,514,137 30.00
31.00	Primary payer payments			59 31.00
32.00	Subtotal (line 30 minus line 31)			3,514,078 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)			240,236 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			168,165 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			113,246 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			3,682,243 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			3,682,243 40.00
41.00	Interim payments			3,792,286 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)			-110,043 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150064

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

Worksheet E-1
Part I
Date/Time Prepared:
2/27/2013 7:31 pm

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,390,722		3,512,590	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	09/30/2012	210,040	09/30/2012	256,959	3.01
3.02		04/10/2012	8,866	04/10/2012	22,737	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		218,906		279,696	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)		5,609,628		3,792,286	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		163,069		110,043	6.02
7.00	Total Medicare program liability (see instructions)		5,446,559		3,682,243	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150064
Component CCN: 15T064

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

Worksheet E-1
Part I
Date/Time Prepared:
2/27/2013 7:31 pm
PPS

Title XVIII

Subprovider -
IRF

		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					0 1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,068,717			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)					0 3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	04/10/2012	2,846			0 3.01
3.02			0			0 3.02
3.03			0			0 3.03
3.04			0			0 3.04
3.05			0			0 3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0			0 3.50
3.51			0			0 3.51
3.52			0			0 3.52
3.53			0			0 3.53
3.54			0			0 3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		2,846			0 3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,071,563			0 4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					0 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)					0 6.00
6.01	SETTLEMENT TO PROVIDER		0			0 6.01
6.02	SETTLEMENT TO PROGRAM		13,194			0 6.02
7.00	Total Medicare program liability (see instructions)		1,058,369			0 7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					0 8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150064
Component CCN: 15U064

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

Worksheet E-1
Part I
Date/Time Prepared:
2/27/2013 7:31 pm

Title XVIII Swing Beds - SNF 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		28,861		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		28,861		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		28,861		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 150064

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

Worksheet E-1
Part II
Date/Time Prepared:
2/27/2013 7:31 pm

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			1,486 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			2,251 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			240 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			3,993 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			96,857,800 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			1,617,256 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,311,740 8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,387,362 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			-75,622 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet E-2
Component CCN: 15U064		Date/Time Prepared: 2/27/2013 7:31 pm
Title XVIII	Swing Beds - SNF	PPS

		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	30,017	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	105	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	30,017	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	30,017	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	30,017	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,156	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	28,861	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	28,861	0	19.00
20.00	Interim payments	28,861	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet E-2
		Component CCN: 15U064		Date/Time Prepared: 2/27/2013 7:31 pm
		Title XIX	Swing Beds - SNF	PPS
			Part A	Part B
			1.00	2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0	2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)		0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days		0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	8.00
9.00	Primary payer payments (see instructions)		0	9.00
10.00	Subtotal (line 8 minus line 9)		0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	11.00
12.00	Subtotal (line 10 minus line 11)		0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)		0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	16.00
17.00	Reimbursable bad debts (see instructions)		0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)		0	19.00
20.00	Interim payments		0	20.00
21.00	Tentative settlement (for contractor use only)		0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)		0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064 Component CCN: 15T064	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part III Date/Time Prepared: 2/27/2013 7:31 pm
		Title XVIIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			1,048,144 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0225 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			20,652 3.00
4.00	Outlier Payments			1,226 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			2.639344 10.00
11.00	Medical Education Adjustment Factor $\{((1 + (\text{line } 9/\text{line } 10)) \text{ raised to the power of } .6876 - 1)\}$.			0.000000 11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).			0 12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)			1,070,022 13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)			0 14.00
15.00	Organ acquisition			0 15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 16.00
17.00	Subtotal (see instructions)			1,070,022 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			1,070,022 19.00
20.00	Deductibles			12,596 20.00
21.00	Subtotal (line 19 minus line 20)			1,057,426 21.00
22.00	Coinsurance			0 22.00
23.00	Subtotal (line 21 minus line 22)			1,057,426 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			1,347 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			943 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			1,058,369 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			1,058,369 32.00
33.00	Interim payments			1,071,563 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus the sum lines 33 and 34)			-13,194 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4			1,226 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2013 7:31 pm	
		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		653,640		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)		653,640	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)		653,640	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		457,169		8.00
9.00	Ancillary service charges		890,218	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)		1,347,387	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)		1,347,387	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		693,747	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	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)		653,640	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)		653,640	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		653,640	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)		653,640	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		653,640	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)		653,640	0	40.00
41.00	Interim payments		1,876,536	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		-1,222,896	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064 Component CCN: 15T064	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2013 7:31 pm
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 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	22,165		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)	22,165	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)	22,165	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	45,272		8.00
9.00	Ancillary service charges	0	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)	45,272	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)	45,272	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	23,107	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	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)	22,165	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	0	24.00
25.00	Capital exception payments (see instructions)	0	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)	22,165	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	22,165	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	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	22,165	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	22,165	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	22,165	0	40.00
41.00	Interim payments	41,310	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	-19,145	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: 150064

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

Worksheet G

Date/Time Prepared:
2/27/2013 7:31 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,480,670	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,363,132	0	0	0	4.00
5.00	Other receivable	393,013	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	866,863	0	0	0	7.00
8.00	Prepaid expenses	602,056	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	12,705,734	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,244,594	0	0	0	12.00
13.00	Land improvements	541,226	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	51,742,331	0	0	0	15.00
16.00	Accumulated depreciation	-50,258,708	0	0	0	16.00
17.00	Leasehold improvements	193,951	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	22,631,041	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	26,094,435	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	15,890,722	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,869,506	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	17,760,228	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	56,560,397	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	847,362	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,165,980	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,754,841	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,768,183	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	23,808,268	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	23,808,268	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	28,576,451	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	27,983,946				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)	27,983,946	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	56,560,397	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150064

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

Worksheet G-1

Date/Time Prepared:
2/27/2013 7:31 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
1.00	Fund balances at beginning of period		24,434,711		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,994,664			2.00
3.00	Total (sum of line 1 and line 2)		27,429,375		0	3.00
4.00	INTEREST IN FOUNDATION	554,571		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		554,571		0	10.00
11.00	Subtotal (line 3 plus line 10)		27,983,946		0	11.00
12.00		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)		27,983,946		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150064

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

Worksheet G-1

Date/Time Prepared:
2/27/2013 7:31 pm

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00						1.00
			0		0	
2.00						2.00
3.00			0		0	3.00
4.00						4.00
	0			0		
5.00						5.00
	0			0		
6.00						6.00
	0			0		
7.00						7.00
	0			0		
8.00						8.00
	0			0		
9.00						9.00
	0			0		
10.00			0		0	10.00
11.00			0		0	11.00
12.00						12.00
	0			0		
13.00						13.00
	0			0		
14.00						14.00
	0			0		
15.00						15.00
	0			0		
16.00						16.00
	0			0		
17.00						17.00
	0			0		
18.00			0		0	18.00
19.00			0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150064

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	5,223,123		5,223,123	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	1,169,849		1,169,849	3.00
4.00	SUBPROVIDER	0		0	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)	6,392,972		6,392,972	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,033,114		3,033,114	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)	3,033,114		3,033,114	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	9,426,086		9,426,086	17.00
18.00	Ancillary services	16,902,387	73,810,707	90,713,094	18.00
19.00	Outpatient services	4,451,852	6,942,320	11,394,172	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		904,631	904,631	22.00
23.00	AMBULANCE SERVICES	0	1,173,482	1,173,482	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	249,225	249,225	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	30,780,325	83,080,365	113,860,690	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		52,062,779		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)		52,062,779		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150064

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

Worksheet G-3

Date/Time Prepared:
2/27/2013 7:31 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	113,860,690	1.00
2.00	Less contractual allowances and discounts on patients' accounts	58,062,456	2.00
3.00	Net patient revenues (line 1 minus line 2)	55,798,234	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	52,062,779	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,735,455	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	3,299,335	24.00
24.01	UNREALIZED LOSS	-140,457	24.01
24.02	GAIN/LOSS ON DISPOSAL OF ASSETS	-11,638	24.02
24.03	NET UNREALIZED GAIN (LOSS) ON INVEST	1,761,094	24.03
25.00	Total other income (sum of lines 6-24)	4,908,334	25.00
26.00	Total (line 5 plus line 25)	8,643,789	26.00
27.00	OTHER EXPENSES (SPECIFY)	5,649,125	27.00
27.01		0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	5,649,125	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,994,664	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150064

Period: From 10/01/2011

Worksheet H

HHA CCN: 157097

To 09/30/2012

Date/Time Prepared: 2/27/2013 7:31 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	1.00
2.00	Capital Related - Movable Equipment			0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	163,751	0	35,706	0	131,560	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	291,451	0	0	0	0	6.00
7.00	Physical Therapy	85,864	0	0	0	0	7.00
8.00	Occupational Therapy	72,035	0	0	0	0	8.00
9.00	Speech Pathology	1,070	0	0	0	0	9.00
10.00	Medical Social Services	36,908	0	0	0	0	10.00
11.00	Home Health Aide	101,453	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	752,532	0	35,706	0	131,560	24.00

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

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150064

Period: From 10/01/2011

Worksheet H

HHA CCN: 157097

To 09/30/2012

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		Total (sum of col.s. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	331,017	-31,980	299,037	0	299,037	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	291,451	0	291,451	0	291,451	6.00
7.00	Physical Therapy	85,864	0	85,864	0	85,864	7.00
8.00	Occupational Therapy	72,035	0	72,035	0	72,035	8.00
9.00	Speech Pathology	1,070	0	1,070	0	1,070	9.00
10.00	Medical Social Services	36,908	0	36,908	0	36,908	10.00
11.00	Home Health Aide	101,453	0	101,453	0	101,453	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	919,798	-31,980	887,818	0	887,818	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: 150064	Period: From 10/01/2011	Worksheet H-1
		HHA CCN: 157097	To 09/30/2012	Part I
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	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
		Bldgs & Fixtures	Movable Equipment			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	299,037	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	291,451	0	0	0	6.00
7.00	Physical Therapy	85,864	0	0	0	7.00
8.00	Occupational Therapy	72,035	0	0	0	8.00
9.00	Speech Pathology	1,070	0	0	0	9.00
10.00	Medical Social Services	36,908	0	0	0	10.00
11.00	Home Health Aide	101,453	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	887,818	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 150064	Period: From 10/01/2011	Worksheet H-1
		HHA CCN: 157097	To 09/30/2012	Part I
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	Subtotal (col s. 0-4) 4A.00	Administrative & General 5.00	Total (col s. 4A + 5) 6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures	0		1.00
2.00	Capital Related - Movable Equipment	0		2.00
3.00	Plant Operation & Maintenance	0		3.00
4.00	Transportation			4.00
5.00	Administrative and General	299,037	299,037	5.00
HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	291,451	148,026	439,477
7.00	Physical Therapy	85,864	43,610	129,474
8.00	Occupational Therapy	72,035	36,586	108,621
9.00	Speech Pathology	1,070	543	1,613
10.00	Medical Social Services	36,908	18,745	55,653
11.00	Home Health Aide	101,453	51,527	152,980
12.00	Supplies (see instructions)	0	0	0
13.00	Drugs	0	0	0
14.00	DME	0	0	0
HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0	0
16.00	Respiratory Therapy	0	0	0
17.00	Private Duty Nursing	0	0	0
18.00	Clinic	0	0	0
19.00	Health Promotion Activities	0	0	0
20.00	Day Care Program	0	0	0
21.00	Home Delivered Meals Program	0	0	0
22.00	Homemaker Service	0	0	0
23.00	All Others (specify)	0	0	0
24.00	Total (sum of lines 1-23)	887,818		887,818

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 150064
HHA CCN: 157097

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

Worksheet H-1
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		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)				
		1.00	2.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0	0	-299,037	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-299,037	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS	Provider CCN: 150064	Period:	Worksheet H-1
	HHA CCN: 157097	From 10/01/2011 To 09/30/2012	Part II Date/Time Prepared: 2/27/2013 7:31 pm
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		Administrative & General (ACCUM. COST)	
		5.00	
GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures		1.00
2.00	Capital Related - Movable Equipment		2.00
3.00	Plant Operation & Maintenance		3.00
4.00	Transportation (see instructions)		4.00
5.00	Administrative and General	588,781	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	291,451	6.00
7.00	Physical Therapy	85,864	7.00
8.00	Occupational Therapy	72,035	8.00
9.00	Speech Pathology	1,070	9.00
10.00	Medical Social Services	36,908	10.00
11.00	Home Health Aide	101,453	11.00
12.00	Supplies (see instructions)	0	12.00
13.00	Drugs	0	13.00
14.00	DME	0	14.00
HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	15.00
16.00	Respiratory Therapy	0	16.00
17.00	Private Duty Nursing	0	17.00
18.00	Clinic	0	18.00
19.00	Health Promotion Activities	0	19.00
20.00	Day Care Program	0	20.00
21.00	Home Delivered Meals Program	0	21.00
22.00	Homemaker Service	0	22.00
23.00	All Others (specify)	0	23.00
24.00	Total (sum of lines 1-23)	588,781	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	299,037	25.00
26.00	Unit Cost Multiplier	0.507892	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150064
HHA CCN: 157097

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

Worksheet H-2
Part I
Date/Time Prepared:
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Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
1.00 Administrative and General	0	12,510		179,936	192,446	32,051	1.00
2.00 Skilled Nursing Care	439,477	0		0	439,477	73,193	2.00
3.00 Physical Therapy	129,474	0		0	129,474	21,564	3.00
4.00 Occupational Therapy	108,621	0		0	108,621	18,091	4.00
5.00 Speech Pathology	1,613	0		0	1,613	269	5.00
6.00 Medical Social Services	55,653	0		0	55,653	9,269	6.00
7.00 Home Health Aide	152,980	0		0	152,980	25,478	7.00
8.00 Supplies (see instructions)	0	0		0	0	0	8.00
9.00 Drugs	0	0		0	0	0	9.00
10.00 DME	0	0		0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0		0	0	0	11.00
12.00 Respiratory Therapy	0	0		0	0	0	12.00
13.00 Private Duty Nursing	0	0		0	0	0	13.00
14.00 Clinic	0	0		0	0	0	14.00
15.00 Health Promotion Activities	0	0		0	0	0	15.00
16.00 Day Care Program	0	0		0	0	0	16.00
17.00 Home Delivered Meals Program	0	0		0	0	0	17.00
18.00 Homemaker Service	0	0		0	0	0	18.00
19.00 All Others (specify)	0	0		0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	887,818	12,510		179,936	1,080,264	179,915	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: 150064

Period:

Worksheet H-2

HHA CCN: 157097

From 10/01/2011
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Cost Center Description		OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		7.00	7.01	8.00	9.00	10.00	
1.00	Administrative and General	28,623	0	8,973	12,128	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	28,623	0	8,973	12,128	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150064

Period:

Worksheet H-2

HHA CCN: 157097

From 10/01/2011
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	27,004	50,673	0	0	13,793	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	27,004	50,673	0	0	13,793	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150064

Period: From 10/01/2011

Worksheet H-2

HHA CCN: 157097

To 09/30/2012

Part I
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	365,691	0	365,691			1.00
2.00	Skilled Nursing Care	512,670	0	512,670	181,020	693,690	2.00
3.00	Physical Therapy	151,038	0	151,038	53,330	204,368	3.00
4.00	Occupational Therapy	126,712	0	126,712	44,741	171,453	4.00
5.00	Speech Pathology	1,882	0	1,882	665	2,547	5.00
6.00	Medical Social Services	64,922	0	64,922	22,923	87,845	6.00
7.00	Home Health Aide	178,458	0	178,458	63,012	241,470	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	1,401,373	0	1,401,373	365,691	1,401,373	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.				0.353092		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: 150064
HHA CCN: 157097

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

Worksheet H-2
Part II
Date/Time Prepared:
2/27/2013 7:31 pm

Home Health Agency I

PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00					
1.00 Administrative and General	2,638		765,479	5A	192,446	2,638	1.00
2.00 Skilled Nursing Care	0		0		439,477	0	2.00
3.00 Physical Therapy	0		0		129,474	0	3.00
4.00 Occupational Therapy	0		0		108,621	0	4.00
5.00 Speech Pathology	0		0		1,613	0	5.00
6.00 Medical Social Services	0		0		55,653	0	6.00
7.00 Home Health Aide	0		0		152,980	0	7.00
8.00 Supplies (see instructions)	0		0		0	0	8.00
9.00 Drugs	0		0		0	0	9.00
10.00 DME	0		0		0	0	10.00
11.00 Home Dialysis Aide Services	0		0		0	0	11.00
12.00 Respiratory Therapy	0		0		0	0	12.00
13.00 Private Duty Nursing	0		0		0	0	13.00
14.00 Clinic	0		0		0	0	14.00
15.00 Health Promotion Activities	0		0		0	0	15.00
16.00 Day Care Program	0		0		0	0	16.00
17.00 Home Delivered Meals Program	0		0		0	0	17.00
18.00 Homemaker Service	0		0		0	0	18.00
19.00 All Others (specify)	0		0		0	0	19.00
20.00 Total (sum of lines 1-19)	2,638		765,479		1,080,264	2,638	20.00
21.00 Total cost to be allocated	12,510		179,936		179,915	28,623	21.00
22.00 Unit cost multiplier	4.742229		0.235063		0.166547	10.850265	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 150064 HHA CCN: 157097	Period: From 10/01/2011 To 09/30/2012	Worksheet H-2 Part II Date/Time Prepared: 2/27/2013 7:31 pm PPS
		Home Health Agency I	

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
		7.01	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	3,115	2,638	0	36,821	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	3,115	2,638	0	36,821	20.00
21.00	Total cost to be allocated	0	8,973	12,128	0	27,004	21.00
22.00	Unit cost multiplier	0.000000	2.880578	4.597422	0.000000	0.733386	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 150064 HHA CCN: 157097	Period: From 10/01/2011 To 09/30/2012	Worksheet H-2 Part II Date/Time Prepared: 2/27/2013 7:31 pm PPS
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Cost Center Description	NURSING ADMINISTRATION (FTE'S)	CENTRAL SERVICES & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
	13.00	14.00	15.00	16.00		
1.00 Administrative and General	1,478	0	0	904,631		1.00
2.00 Skilled Nursing Care	0	0	0	0		2.00
3.00 Physical Therapy	0	0	0	0		3.00
4.00 Occupational Therapy	0	0	0	0		4.00
5.00 Speech Pathology	0	0	0	0		5.00
6.00 Medical Social Services	0	0	0	0		6.00
7.00 Home Health Aide	0	0	0	0		7.00
8.00 Supplies (see instructions)	0	0	0	0		8.00
9.00 Drugs	0	0	0	0		9.00
10.00 DME	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0		13.00
14.00 Clinic	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0		19.00
20.00 Total (sum of lines 1-19)	1,478	0	0	904,631		20.00
21.00 Total cost to be allocated	50,673	0	0	13,793		21.00
22.00 Unit cost multiplier	34.284844	0.000000	0.000000	0.015247		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150064 HHA CCN: 157097		Period: From 10/01/2011 To 09/30/2012		Worksheet H-3 Parts I-III Date/Time Prepared: 2/27/2013 7:31 pm	
		Title XVIII		Home Health Agency I		PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	693,690		693,690	5,063	1.00
2.00	Physical Therapy	3.00	204,368	0	204,368	901	2.00
3.00	Occupational Therapy	4.00	171,453	0	171,453	728	3.00
4.00	Speech Pathology	5.00	2,547	0	2,547	28	4.00
5.00	Medical Social Services	6.00	87,845		87,845	60	5.00
6.00	Home Health Aide	7.00	241,470		241,470	9,531	6.00
7.00	Total (sum of lines 1-6)		1,401,373	0	1,401,373	16,311	7.00
				Program Visits			
				Part B			
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	1,107	1,500		8.00
9.00	Physical Therapy		99915	323	247		9.00
10.00	Occupational Therapy		99915	266	278		10.00
11.00	Speech Pathology		99915	19	3		11.00
12.00	Medical Social Services		99915	18	25		12.00
13.00	Home Health Aide		99915	310	970		13.00
14.00	Total (sum of lines 8-13)			2,043	3,023		14.00
				Total HHA Costs (cols. 1 + 2)		Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00
				Total HHA Charge (from provider records)		HHA Shared Ancillary Costs (col. 1 x col. 2)	
		0	1.00	2.00	3.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy		66.00	0.660036	0	0	1.00
2.00	Occupational Therapy						2.00
3.00	Speech Pathology						3.00
4.00	Cost of Medical Supplies		71.00	0.447445	0	0	4.00
5.00	Cost of Drugs		73.00	0.310107	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150064
HHA CCN: 157097

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

Worksheet H-3
Parts I-III
Date/Time Prepared:
2/27/2013 7:31 pm
PPS

Title XVIII

Home Health Agency I

Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Program Visits			
			Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	5.00	6.00	7.00	8.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
Cost Per Visit Computation						
1.00	Skilled Nursing Care	137.01	1,107	1,500		1.00
2.00	Physical Therapy	226.82	323	247		2.00
3.00	Occupational Therapy	235.51	266	278		3.00
4.00	Speech Pathology	90.96	19	3		4.00
5.00	Medical Social Services	1,464.08	18	25		5.00
6.00	Home Health Aide	25.34	310	970		6.00
7.00	Total (sum of lines 1-6)		2,043	3,023		7.00
Cost Center Description						
		5.00	6.00	7.00	8.00	9.00
Limitation Cost Computation						
8.00	Skilled Nursing Care					8.00
9.00	Physical Therapy					9.00
10.00	Occupational Therapy					10.00
11.00	Speech Pathology					11.00
12.00	Medical Social Services					12.00
13.00	Home Health Aide					13.00
14.00	Total (sum of lines 8-13)					14.00
Program Covered Charges						
Cost Center Description	Ratio (col. 3 ÷ col. 4)	Part A	Part B			
			Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00	
Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0.000000				15.00
16.00	Cost of Drugs	0.000000		0	0	16.00
Cost Center Description						
			Transfer to Part I as Indicated			
			4.00			
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	col. 2, line 2.00				1.00
2.00	Occupational Therapy					2.00
3.00	Speech Pathology					3.00
4.00	Cost of Medical Supplies	col. 2, line 15.00				4.00
5.00	Cost of Drugs	col. 2, line 16.00				5.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150064 HHA CCN: 157097		Period: From 10/01/2011 To 09/30/2012		Worksheet H-3 Parts I-III Date/Time Prepared: 2/27/2013 7:31 pm	
				Title XVII		Home Health Agency I	
		Title XVII		Home Health Agency I		PPS	
Cost Center Description	Cost of Services			Total Program Cost (sum of col.s. 9-10)			
	Part A	Part B					
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				
	9.00	10.00	11.00	12.00			
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	151,670	205,515		357,185		1.00
2.00	Physical Therapy	73,263	56,025		129,288		2.00
3.00	Occupational Therapy	62,646	65,472		128,118		3.00
4.00	Speech Pathology	1,728	273		2,001		4.00
5.00	Medical Social Services	26,353	36,602		62,955		5.00
6.00	Home Health Aide	7,855	24,580		32,435		6.00
7.00	Total (sum of lines 1-6)	323,515	388,467		711,982		7.00
Cost Center Description							
		10.00	11.00	12.00			
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00
Cost of Services							
Cost Center Description	Part A	Part B					
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				
	9.00	10.00	11.00				
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies						15.00
16.00	Cost of Drugs		0	0			16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 150064 HHA CCN: 157097	Period: From 10/01/2011 To 09/30/2012	Worksheet H-4 Part I-II Date/Time Prepared: 2/27/2013 7:31 pm
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	2.00
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	8.00
9.00	Primary payer amounts	0	0	9.00
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		283,516	348,938
12.00	Total PPS Reimbursement - Full Episodes with Outliers		4,094	4,318
13.00	Total PPS Reimbursement - LUPA Episodes		8,890	7,915
14.00	Total PPS Reimbursement - PEP Episodes		1,270	3,346
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		1,118	500
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	95
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		298,888	365,112
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		298,888	365,112
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		298,888	365,112
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		298,888	365,112
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		298,888	365,112
32.00	Interim payments (see instructions)		298,888	365,112
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0

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

Provider CCN: 150064
HHA CCN: 157097

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

Worksheet H-5
Date/Time Prepared:
2/27/2013 7:31 pm
PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		298,888		365,112	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)		298,888		365,112	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)		298,888		365,112	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150064

Period: From 10/01/2011

Worksheet K

Hospice CCN: 151548

To 09/30/2012

Date/Time Prepared: 2/27/2013 7:31 pm

		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	0	0	0	0	39,994	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	32,601	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	3,514	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	8,812	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	Total (sum of lines 1 thru 38)	44,927	0	0	0	39,994	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150064

Period: From 10/01/2011

Worksheet K

Hospice CCN: 151548

To 09/30/2012

Date/Time Prepared: 2/27/2013 7:31 pm

		Hospice I					
		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	39,994	0	39,994	0	39,994	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	32,601	0	32,601	0	32,601	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	3,514	0	3,514	0	3,514	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	8,812	0	8,812	0	8,812	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	Total (sum of lines 1 thru 38)	84,921	0	84,921	0	84,921	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150064
 Hospice CCN: 151548

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

Worksheet K-1
 Date/Time Prepared:
 2/27/2013 7:31 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	32,601	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	3,514	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	3,514	0	32,601	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150064

Period: From 10/01/2011

Worksheet K-1

Hospice CCN: 151548

To 09/30/2012

Date/Time Prepared: 2/27/2013 7:31 pm

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	0	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	32,601	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	3,514	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		8,812	0	8,812	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	8,812	0	44,927	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150064
 Hospice CCN: 151548

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

Worksheet K-4
 Part I
 Date/Time Prepared:
 2/27/2013 7:31 pm

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	39,994	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	32,601	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	3,514	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	8,812	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	Total (sum of lines 1 thru 38)	84,921	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST		Provider CCN: 150064	Period: From 10/01/2011	Worksheet K-4
		Hospice CCN: 151548	To 09/30/2012	Part I Date/Time Prepared: 2/27/2013 7:31 pm

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col . 5A ± col . 6)	
		5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance					3.00
4.00	Transportation - Staff					4.00
5.00	Volunteer Service Coordination	0				5.00
6.00	Administrative and General	0	39,994	39,994		6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	0	32,601	29,022	61,623	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	0	3,514	3,128	6,642	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	8,812	7,844	16,656	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	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)	0	84,921		84,921	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064

Period: From 10/01/2011

Worksheet K-4

Hospice CCN: 151548

To 09/30/2012

Part II
Date/Time Prepared:
2/27/2013 7:31 pm

		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: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet K-4 Part II Date/Time Prepared: 2/27/2013 7:31 pm
		Hospice CCN: 151548	Hospice I	
		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination	0		5.00
6.00	Administrative and General	-39,994	44,927	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	32,601	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	0	12.00
13.00	Occupational Therapy	0	0	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	3,514	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	8,812	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	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)		39,994	39.00
40.00	Unit Cost Multiplier		0.890200	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150064

Period: From 10/01/2011

Worksheet K-5

Hospice CCN: 151548

To 09/30/2012

Part I
Date/Time Prepared:
2/27/2013 7:31 pm

Hospice I

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
1.00 Administrative and General			0	10,561	10,561	1,759	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	61,623		0	0	61,623	10,263	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	6,642		0	0	6,642	1,106	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	16,656		0	0	16,656	2,774	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)	84,921		0	10,561	95,482	15,902	34.00
35.00 Unit Cost Multiplier (see instructions)					0.000000		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150064

Period:

Worksheet K-5

Hospice CCN: 151548

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

Part I
Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description		Hospice I					
		OPERATION OF PLANT 7.00	OPERATION OF PLANT 7.01	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
1.00	Administrative and General	0	0	32	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	32	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150064

Period: From 10/01/2011

Worksheet K-5

Hospice CCN: 151548

To 09/30/2012

Part I
Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description		Hospice I					
		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	3,800	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	3,800	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150064

Period: From 10/01/2011

Worksheet K-5

Hospice CCN: 151548

To 09/30/2012

Part I
Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description		Hospice I					
		Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	16,152					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	71,886	0	71,886	11,721	83,607	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	7,748	0	7,748	1,263	9,011	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	19,430	0	19,430	3,168	22,598	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)	115,216	0	115,216		115,216	34.00
35.00	Unit Cost Multiplier (see instructions)				0.163046		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150064

Period:

Worksheet K-5

Hospice CCN: 151548

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

Part II
Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description		CAPITAL RELATED COSTS		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)				
		1.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	0	44,927	0	10,561	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	61,623	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	6,642	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	16,656	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	44,927		95,482	0	34.00
35.00	Total cost to be allocated	0	10,561		15,902	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.235070		0.166544	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150064

Period:

Worksheet K-5

Hospice CCN: 151548

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

Part II
Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description		Hospice I						
		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)		
		7.01	8.00	9.00	10.00	11.00		
1.00	Administrative and General	0	0	11	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	11	0	0	0	0	34.00
35.00	Total cost to be allocated	0	32	0	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	2.909091	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150064

Hospice CCN: 151548

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

Worksheet K-5
Part II
Date/Time Prepared:
2/27/2013 7:31 pm

Cost Center Description	Hospice I						
	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY			
	(FTE'S)	(100%)		(GROSS CHARGES)			
	13.00	14.00	15.00	16.00			
1.00 Administrative and General	0	0	0	249,225		1.00	
2.00 Inpatient - General Care	0	0	0	0		2.00	
3.00 Inpatient - Respite Care	0	0	0	0		3.00	
4.00 Physician Services	0	0	0	0		4.00	
5.00 Nursing Care	0	0	0	0		5.00	
6.00 Nursing Care-Continuous Home Care	0	0	0	0		6.00	
7.00 Physical Therapy	0	0	0	0		7.00	
8.00 Occupational Therapy	0	0	0	0		8.00	
9.00 Speech/ Language Pathology	0	0	0	0		9.00	
10.00 Medical Social Services	0	0	0	0		10.00	
11.00 Spiritual Counseling	0	0	0	0		11.00	
12.00 Dietary Counseling	0	0	0	0		12.00	
13.00 Counseling - Other	0	0	0	0		13.00	
14.00 Home Health Aide and Homemaker	0	0	0	0		14.00	
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00	
16.00 Other	0	0	0	0		16.00	
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0		17.00	
18.00 Analgesics	0	0	0	0		18.00	
19.00 Sedatives / Hypnotics	0	0	0	0		19.00	
20.00 Other - Specify	0	0	0	0		20.00	
21.00 Durable Medical Equipment/Oxygen	0	0	0	0		21.00	
22.00 Patient Transportation	0	0	0	0		22.00	
23.00 Imaging Services	0	0	0	0		23.00	
24.00 Labs and Diagnostics	0	0	0	0		24.00	
25.00 Medical Supplies	0	0	0	0		25.00	
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0		26.00	
27.00 Radiation Therapy	0	0	0	0		27.00	
28.00 Chemotherapy	0	0	0	0		28.00	
29.00 Other	0	0	0	0		29.00	
30.00 Bereavement Program Costs	0	0	0	0		30.00	
31.00 Volunteer Program Costs	0	0	0	0		31.00	
32.00 Fundraising	0	0	0	0		32.00	
33.00 Other Program Costs	0	0	0	0		33.00	
34.00 Total (sum of lines 1 thru 33) (2)	0	0	0	249,225		34.00	
35.00 Total cost to be allocated	0	0	0	3,800		35.00	
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.015247		36.00	

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 150064 Hospice CCN: 151548		Period: From 10/01/2011 To 09/30/2012		Worksheet K-5 Part III Date/Time Prepared: 2/27/2013 7:31 pm	
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	0.660036	0	0	1.00	
2.00	OCCUPATIONAL THERAPY	67.00				2.00	
3.00	SPEECH PATHOLOGY	68.00				3.00	
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.310107	0	0	4.00	
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00	
6.00	LABORATORY	60.00	0.182320	0	0	6.00	
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	6.01	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.447445	0	0	7.00	
8.00	CLINIC	93.00	0.961327	0	0	8.00	
8.01	BIC	93.01	0.684548	0	0	8.01	
8.02	UCIC	93.02	0.000000	0	0	8.02	
8.03	CIC	93.03	0.000000	0	0	8.03	
8.04	RIC	93.04	0.000000	0	0	8.04	
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: 150064	Period: From 10/01/2011	Worksheet K-6
		Hospice CCN: 151548	To 09/30/2012	Date/Time Prepared: 2/27/2013 7:31 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				115,216	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				1,100	2.00
3.00	Average cost per diem (line 1 divided by line 2)				104.74	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	1,100				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	115,214				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		0			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		0			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			0		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			0		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150064	Period: From 10/01/2011 To 09/30/2012	Worksheet L Parts I-III Date/Time Prepared: 2/27/2013 7:31 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		369,462	1.00
2.00	Capital DRG outlier payments		0	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		10.91	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		369,462	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00