

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet S Parts I-III Date/Time Prepared: 2/25/2014 4:45 pm
--	----------------------	---	--

<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 2/25/2014	Time: 4:45 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 DEKALB MEMORIAL HOSPITAL ( 150045 ) for the cost reporting period beginning 10/01/2012 and ending 09/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	70,368	8,677	26,584	-386,187	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
9.00 HOME HEALTH AGENCY I	0	0	2	0	0	9.00
200.00 Total	0	70,368	8,679	26,584	-386,187	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150045		Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part I Date/Time Prepared: 2/25/2014 4:27 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1316 EAST 7TH STREET			PO Box:						1.00	
2.00	City: AUBURN			State: IN		Zip Code: 46706-		County: DEKALB		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00
								V	XVIII	XIX	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		DEKALB MEMORIAL HOSPITAL	150045	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA		DEKALB HOME HEALTH AGENCY	157157	99915		07/09/1985	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice		DEKALB HOSPICE	151559	99915		11/06/1996				14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
17.10	Hospital-Based (CORF) I										17.10
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2012	09/30/2013		20.00	
21.00	Type of Control (see instructions)						2		21.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						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.	480	457	0	11	751	0		24.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		25.00		
							Urban/Rural S	Date of Geogr			
							1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						2		26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2		27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part I Date/Time Prepared: 2/25/2014 4:27 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 this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y			39.00
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part I Date/Time Prepared: 2/25/2014 4:27 pm			
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00	2.00	3.00	4.00			
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.		0.00	0.00	61.20		
				1.00			
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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		
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>							
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 Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
<u>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.</u>							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
<u>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</u>							
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150045		Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part I Date/Time Prepared: 2/25/2014 4:27 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		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
<b>Inpatient Psychiatric Facility PPS</b>							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
					1.00		
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
<b>TEFRA Providers</b>							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
					V	XIX	
					1.00	2.00	
<b>Title V and XIX Services</b>							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N			106.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part I Date/Time Prepared: 2/25/2014 4:27 pm		
		V	XIX			
		1.00	2.00			
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	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		
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	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
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	281,393	22,000	3,364		118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N		Y		120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
<b>Transplant Center Information</b>						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
<b>All Providers</b>						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part I Date/Time Prepared: 2/25/2014 4:27 pm			
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.					N	145.00
						1.00	
						2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N	146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
161.10	CORF		N	N	N	161.10	
						1.00	
165.00	Multi campus 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
						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)					0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.75	169.00
						1.00	
						2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			10/01/2012	09/30/2013	170.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part II Date/Time Prepared: 2/25/2014 4:27 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		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	01/02/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150045

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
2/25/2014 4:27 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
				1.00	2.00
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI CHAEL		ALESSANDRI NI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7959		MALESSANDRI NI@BLUEANDCO.COM	43.00

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	01/02/2014	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 150045

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Trips	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	41	14,965	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		41	14,965	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,190	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		47	17,155	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		47				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150045

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,224	414	3,967			1.00
2.00 HMO and other (see instructions)	1,093	1,189				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,224	414	3,967			7.00
8.00 INTENSIVE CARE UNIT	543	0	1,429			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	937			13.00
14.00 Total (see instructions)	1,767	414	6,333	0.00	431.31	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	2,707	0	9,024	0.00	2.73	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	3,602	0	4,000	0.00	13.23	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	447.27	27.00
28.00 Observation Bed Days		127	681			28.00
29.00 Ambulance Trips	991					29.00
30.00 Employee discount days (see instruction)			155			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		96	155			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150045

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	544	109	2,011	1.00
2.00	HMO and other (see instructions)			325			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	544	109	2,011	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150045

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
2/25/2014 4:27 pm

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	23,349,921	0	23,349,921	930,343.00	25.10
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		103,232	0	103,232	1,046.00	98.69
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		6,835,788	20,774	6,856,562	244,282.00	28.07
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor (see instructions)		1,756,621	0	1,756,621	30,612.00	57.38
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		223,229	0	223,229	2,371.00	94.15
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		5,647,983	0	5,647,983		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		2,074,412	0	2,074,412		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		13,286	0	13,286		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FOHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	4.00	226,343	348	226,691	6,365.00	35.62
27.00	Administrative & General	5.00	3,013,977	-31,103	2,982,874	130,416.00	22.87
28.00	Administrative & General under contract (see inst.)		80,820	0	80,820	341.00	237.01
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	532,246	814	533,060	22,713.00	23.47
31.00	Laundry & Linen Service	8.00	106,861	163	107,024	8,078.00	13.25
32.00	Housekeeping	9.00	553,856	847	554,703	47,032.00	11.79
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	506,118	-328,898	177,220	7,286.00	24.32
35.00	Dietary under contract (see instructions)		4,459	0	4,459	86.00	51.85
36.00	Cafeteria	11.00	0	329,672	329,672	23,269.00	14.17
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	673,753	1,030	674,783	17,995.00	37.50
39.00	Central Services and Supply	14.00	139,175	213	139,388	8,781.00	15.87
40.00	Pharmacy	15.00	534,016	817	534,833	12,658.00	42.25
41.00	Medical Records & Medical Records Library	16.00	503,390	770	504,160	28,986.00	17.39

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150045

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
2/25/2014 4:27 pm

		Worksheet A Line Number	Amount Reported	Reclassifi- 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	
42.00	Social Service	17.00	66,866	102	66,968	2,190.00	30.58	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150045

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
2/25/2014 4:27 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	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	23,435,200	0	23,435,200	930,770.00	25.18	1.00
2.00	Excluded area salaries (see instructions)	6,835,788	20,774	6,856,562	244,282.00	28.07	2.00
3.00	Subtotal salaries (line 1 minus line 2)	16,599,412	-20,774	16,578,638	686,488.00	24.15	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,979,850	0	1,979,850	32,983.00	60.03	4.00
5.00	Subtotal wage-related costs (see inst.)	5,661,269	0	5,661,269	0.00	34.15	5.00
6.00	Total (sum of lines 3 thru 5)	24,240,531	-20,774	24,219,757	719,471.00	33.66	6.00
7.00	Total overhead cost (see instructions)	6,941,880	-25,225	6,916,655	316,196.00	21.87	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet S-3 Part IV Date/Time Prepared: 2/25/2014 4:27 pm
-----------------------------	----------------------	---	--

		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	991,183	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401K/TSA Plan Administration Fees	2,096	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	4,580,396	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	47,979	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)	52,373	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	263,477	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	1,715,800	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	33,142	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	49,235	23.00
24.00	<b>Total Wage Related cost (Sum of lines 1 -23)</b>	<b>7,735,681</b>	<b>24.00</b>
<b>Part B - Other than Core Related Cost</b>			
25.00	<b>OTHER WAGE RELATED COSTS (SPECIFY)</b>	<b>110,571</b>	<b>25.00</b>

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150045

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost	96,567	0	1.00
2.00	Hospital	96,567	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 150045 Component CCN: 157157		Period: From 10/01/2012 To 09/30/2013		Worksheet S-4 Date/Time Prepared: 2/25/2014 4:27 pm		
				Home Health Agency I		PPS		
							1.00	
0.00	County	DEKALB					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	166.00	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	3.00	
4.00	Director(s) and Assistant Director(s)				0.00	0.00	4.00	
5.00	Other Administrative Personnel				0.00	0.00	5.00	
6.00	Direct Nursing Service				0.00	0.00	6.00	
7.00	Nursing Supervisor				0.00	0.00	7.00	
8.00	Physical Therapy Service				0.00	0.00	8.00	
9.00	Physical Therapy Supervisor				0.00	0.00	9.00	
10.00	Occupational Therapy Service				0.00	0.00	10.00	
11.00	Occupational Therapy Supervisor				0.00	0.00	11.00	
12.00	Speech Pathology Service				0.00	0.00	12.00	
13.00	Speech Pathology Supervisor				0.00	0.00	13.00	
14.00	Medical Social Service				0.00	0.00	14.00	
15.00	Medical Social Service Supervisor				0.00	0.00	15.00	
16.00	Home Health Aide				0.00	0.00	16.00	
17.00	Home Health Aide Supervisor				0.00	0.00	17.00	
18.00	Other (specify)				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					
		1.00	2.00	3.00	4.00	5.00		
PPS ACTIVITY DATA								
21.00	Skilled Nursing Visits	1,517	46	48	24	1,635	21.00	
22.00	Skilled Nursing Visit Charges	263,775	8,050	7,875	4,200	283,900	22.00	
23.00	Physical Therapy Visits	479	0	14	5	498	23.00	
24.00	Physical Therapy Visit Charges	82,784	0	2,251	692	85,727	24.00	
25.00	Occupational Therapy Visits	0	0	0	0	0	25.00	
26.00	Occupational Therapy Visit Charges	0	0	0	0	0	26.00	
27.00	Speech Pathology Visits	0	0	0	0	0	27.00	
28.00	Speech Pathology Visit Charges	0	0	0	0	0	28.00	
29.00	Medical Social Service Visits	20	0	1	0	21	29.00	
30.00	Medical Social Service Visit Charges	4,811	0	266	0	5,077	30.00	
31.00	Home Health Aide Visits	498	38	0	17	553	31.00	
32.00	Home Health Aide Visit Charges	51,954	3,952	0	1,768	57,674	32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,514	84	63	46	2,707	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)	403,324	12,002	10,392	6,660	432,378	35.00	
36.00	Total Number of Episodes (standard/non outlier)	167		22	4	193	36.00	
37.00	Total Number of Outlier Episodes		1		0	1	37.00	
38.00	Total Non-Routine Medical Supply Charges	11,433	973	97	7	12,510	38.00	

HOSPITAL IDENTIFICATION DATA

Provider CCN: 150045  
Component CCN: 151559

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

Worksheet S-9  
Parts I & II  
Date/Time Prepared:  
2/25/2014 4:27 pm

		Hospice I						
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of col.s. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART I - ENROLLMENT DAYS</b>								
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	3,552	0	701	0	14	3,566	2.00
3.00	Inpatient Respite Care	35	0	0	0	2	37	3.00
4.00	General Inpatient Care	22	0	0	0	2	24	4.00
5.00	Total Hospice Days	3,609	0	701	0	18	3,627	5.00
<b>Part II - CENSUS DATA</b>								
6.00	Number of Patients Receiving Hospice Care	95	0	19	7	0	95	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	37.99	0.00	36.89	0.00	0.00	38.18	8.00
9.00	Unduplicated Census Count	95	0	19	7	0	95	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet S-10 Date/Time Prepared: 2/25/2014 4:27 pm
---	----------------------	---	--

				1.00	
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.375157		1.00
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		2,859,496		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		14,010,495		6.00
7.00	Medicaid cost (line 1 times line 6)		5,256,135		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)		2,396,639		8.00
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone SCHIP		0		9.00
10.00	Stand-alone SCHIP charges		0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
<b>Other state or local government indigent care program (see instructions for each line)</b>					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
<b>Uncompensated care (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		2,396,639		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,155,000	0	1,155,000	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	433,306	0	433,306	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)	433,306	0	433,306	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		4,443,148		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		116,708		27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)		4,326,440		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,623,094		29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,056,400		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,453,039		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150045

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

Worksheet A  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		4,887,788	4,887,788	-31,365	4,856,423	1.00
1.01	00101		27,858	27,858	0	27,858	1.01
1.02	00102		4,376	4,376	0	4,376	1.02
1.03	00103		22,078	22,078	0	22,078	1.03
1.04	00104		11,572	11,572	0	11,572	1.04
1.05	00105		161,692	161,692	0	161,692	1.05
1.06	00106		0	0	0	0	1.06
1.07	00107		56,817	56,817	0	56,817	1.07
1.08	00108		0	0	31,365	31,365	1.08
2.00	00200		0	0	0	0	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	226,343	3,484,552	3,710,895	348	3,711,243	4.00
5.00	00500	3,013,977	7,356,871	10,370,848	-40,160	10,330,688	5.00
7.00	00700	532,246	1,151,603	1,683,849	814	1,684,663	7.00
8.00	00800	106,861	146,942	253,803	163	253,966	8.00
9.00	00900	553,856	301,184	855,040	847	855,887	9.00
10.00	01000	483,992	513,995	997,987	-727,463	270,524	10.00
10.01	01001	22,126	53,888	76,014	34	76,048	10.01
11.00	01100	0	0	0	728,203	728,203	11.00
13.00	01300	673,753	92,397	766,150	1,030	767,180	13.00
14.00	01400	139,175	290,090	429,265	213	429,478	14.00
15.00	01500	534,016	399,676	933,692	817	934,509	15.00
16.00	01600	503,390	118,738	622,128	770	622,898	16.00
17.00	01700	66,866	6,098	72,964	102	73,066	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,390,796	955,152	3,345,948	-921,073	2,424,875	30.00
31.00	03100	843,649	340,518	1,184,167	1,290	1,185,457	31.00
43.00	04300	0	3,046	3,046	307,128	310,174	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,678,201	1,542,954	3,221,155	2,567	3,223,722	50.00
52.00	05200	0	0	0	617,602	617,602	52.00
54.00	05400	1,661,067	1,296,056	2,957,123	-128,447	2,828,676	54.00
60.00	06000	1,370,900	2,164,956	3,535,856	66,734	3,602,590	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	519,276	519,276	6,968	526,244	65.00
66.00	06600	344,227	802,217	1,146,444	-48,540	1,097,904	66.00
66.01	06601	88,792	16,838	105,630	59,687	165,317	66.01
69.00	06900	65,626	23,487	89,113	29,746	118,859	69.00
70.00	07000	0	247,572	247,572	4,171	251,743	70.00
71.00	07100	0	827,203	827,203	0	827,203	71.00
72.00	07200	0	598,620	598,620	0	598,620	72.00
73.00	07300	0	1,541,906	1,541,906	0	1,541,906	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	32,973	8,002	40,975	50	41,025	90.00
91.00	09100	1,181,301	756,530	1,937,831	1,807	1,939,638	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	1,141,903	521,567	1,663,470	16,827	1,680,297	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	717,354	220,039	937,393	9,270	946,663	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300		0	0	0	0	113.00
116.00	11600	176,299	137,461	313,760	1,154	314,914	116.00
118.00		18,549,689	31,611,615	50,161,304	-7,341	50,153,963	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	164,976	132,140	297,116	252	297,368	192.00
192.01	19201	4,612,867	365,712	4,978,579	7,055	4,985,634	192.01
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	22,389	14,960	37,349	34	37,383	194.02
200.00		23,349,921	32,124,427	55,474,348	0	55,474,348	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150045

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

Worksheet A  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-346,537	4,509,886	1.00
1.01	00101	MAC WEST - NEW	0	27,858	1.01
1.02	00102	NORTH ANNEX - NEW	0	4,376	1.02
1.03	00103	GARRETT CLINIC - NEW	0	22,078	1.03
1.04	00104	BUTLER - NEW	0	11,572	1.04
1.05	00105	MAC EAST - NEW	0	161,692	1.05
1.06	00106	GARRETT LAB - NEW	0	0	1.06
1.07	00107	MEDICAL ARTS - NEW	0	56,817	1.07
1.08	00108	DAY SPRING - NEW	0	31,365	1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-650,258	3,060,985	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,934,812	7,395,876	5.00
7.00	00700	OPERATION OF PLANT	-1,207	1,683,456	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-1,186	252,780	8.00
9.00	00900	HOUSEKEEPING	-8,117	847,770	9.00
10.00	01000	DIETARY	-4,279	266,245	10.00
10.01	01001	SNACK BAR	-76,048	0	10.01
11.00	01100	CAFETERIA	-231,454	496,749	11.00
13.00	01300	NURSING ADMINISTRATION	0	767,180	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	429,478	14.00
15.00	01500	PHARMACY	0	934,509	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-646	622,252	16.00
17.00	01700	SOCIAL SERVICE	0	73,066	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-1,605	2,423,270	30.00
31.00	03100	INTENSIVE CARE UNIT	-6,000	1,179,457	31.00
43.00	04300	NURSERY	0	310,174	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-850,408	2,373,314	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	617,602	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-33,958	2,794,718	54.00
60.00	06000	LABORATORY	-34,862	3,567,728	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	526,244	65.00
66.00	06600	PHYSICAL THERAPY	-63,474	1,034,430	66.00
66.01	06601	CARDIAC REHAB	-17,076	148,241	66.01
69.00	06900	ELECTROCARDIOLOGY	-14,810	104,049	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	251,743	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	827,203	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	598,620	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-52,275	1,489,631	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	41,025	90.00
91.00	09100	EMERGENCY	-387,271	1,552,367	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	-419,917	1,260,380	95.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	-71,114	875,549	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	-308	314,606	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,207,622	43,946,341	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	297,368	192.00
192.01	19201	DEKALB MEDICAL SERVICES	-480	4,985,154	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	194.01
194.02	07952	FOUNDATION	0	37,383	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-6,208,102	49,266,246	200.00

RECLASSIFICATIONS

Provider CCN: 150045

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

Worksheet A-6  
Date/Time Prepared:  
2/25/2014 4:27 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
<b>A - CAFETERIA RECLASS</b>						
1.00	CAFETERIA	11.00	329,672	398,531	1.00	
	TOTALS		329,672	398,531		
<b>B - DAYSPRING DEPRECIATION</b>						
1.00	DAY SPRING - NEW	1.08	0	31,365	1.00	
	TOTALS		0	31,365		
<b>C - LABOR DELIVERY NURSERY</b>						
1.00	NURSERY	43.00	201,165	105,963	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	404,521	213,081	2.00	
	TOTALS		605,686	319,044		
<b>D - ANCILLARY SERVICES RECLASS</b>						
1.00	LABORATORY	60.00	44,232	20,405	1.00	
2.00	RESPIRATORY THERAPY	65.00	4,768	2,200	2.00	
3.00	PHYSICAL THERAPY	66.00	6,433	2,968	3.00	
4.00	CARDIAC REHAB	66.01	742	342	4.00	
5.00	ELECTROCARDIOLOGY	69.00	1,893	873	5.00	
6.00	ELECTROENCEPHALOGRAPHY	70.00	2,854	1,317	6.00	
7.00	AMBULANCE SERVICES	95.00	10,320	4,761	7.00	
	TOTALS		71,242	32,866		
<b>E - NORTH ANNEX RECLASS</b>						
1.00	HOME HEALTH AGENCY	101.00	0	8,173	1.00	
2.00	HOSPICE	116.00	0	884	2.00	
	TOTALS		0	9,057		
<b>F - REHABILITATION OFFICE RECLASS</b>						
1.00	CARDIAC REHAB	66.01	56,626	1,841	1.00	
	TOTALS		56,626	1,841		
<b>G - RADIOLOGY ADMIN RECLASS</b>						
1.00	ELECTROCARDIOLOGY	69.00	12,835	14,045	1.00	
	TOTALS		12,835	14,045		
<b>H - BONUS ACCRUAL RECLASS</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	348	0	1.00	
2.00	OPERATION OF PLANT	7.00	814	0	2.00	
3.00	LAUNDRY & LINEN SERVICE	8.00	163	0	3.00	
4.00	HOUSEKEEPING	9.00	847	0	4.00	
5.00	DIETARY	10.00	740	0	5.00	
6.00	SNACK BAR	10.01	34	0	6.00	
7.00	NURSING ADMINISTRATION	13.00	1,030	0	7.00	
8.00	CENTRAL SERVICES & SUPPLY	14.00	213	0	8.00	
9.00	PHARMACY	15.00	817	0	9.00	
10.00	MEDICAL RECORDS & LIBRARY	16.00	770	0	10.00	
11.00	SOCIAL SERVICE	17.00	102	0	11.00	
12.00	ADULTS & PEDIATRICS	30.00	3,657	0	12.00	
13.00	INTENSIVE CARE UNIT	31.00	1,290	0	13.00	
14.00	OPERATING ROOM	50.00	2,567	0	14.00	
15.00	RADIOLOGY-DIAGNOSTIC	54.00	2,541	0	15.00	
16.00	LABORATORY	60.00	2,097	0	16.00	
17.00	PHYSICAL THERAPY	66.00	526	0	17.00	
18.00	CARDIAC REHAB	66.01	136	0	18.00	
19.00	ELECTROCARDIOLOGY	69.00	100	0	19.00	
20.00	CLINIC	90.00	50	0	20.00	
21.00	EMERGENCY	91.00	1,807	0	21.00	
22.00	AMBULANCE SERVICES	95.00	1,746	0	22.00	
23.00	HOME HEALTH AGENCY	101.00	1,097	0	23.00	
24.00	HOSPICE	116.00	270	0	24.00	
25.00	PHYSICIANS PRIVATE OFFICES	192.00	252	0	25.00	
26.00	DEKALB MEDICAL SERVICES	192.01	7,055	0	26.00	
27.00	FOUNDATION	194.02	34	0	27.00	
	TOTALS		31,103	0		
500.00	Grand Total: Increases		1,107,164	806,749	500.00	

RECLASSIFICATIONS

Provider CCN: 150045

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

Worksheet A-6  
Date/Time Prepared:  
2/25/2014 4:27 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - CAFETERIA RECLASS</b>							
1.00	DIETARY	10.00	329,672	398,531	0		1.00
	TOTALS		329,672	398,531			
<b>B - DAYSPRING DEPRECIATION</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	31,365	9		1.00
	TOTALS		0	31,365			
<b>C - LABOR DELIVERY NURSERY</b>							
1.00	ADULTS & PEDIATRICS	30.00	605,686	319,044	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		605,686	319,044			
<b>D - ANCILLARY SERVICES RECLASS</b>							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	71,242	32,866	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	TOTALS		71,242	32,866			
<b>E - NORTH ANNEX RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,057	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	9,057			
<b>F - REHABILITATION OFFICE RECLASS</b>							
1.00	PHYSICAL THERAPY	66.00	56,626	1,841	0		1.00
	TOTALS		56,626	1,841			
<b>G - RADIOLOGY ADMIN RECLASS</b>							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	12,835	14,045	0		1.00
	TOTALS		12,835	14,045			
<b>H - BONUS ACCRUAL RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	31,103	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
	TOTALS		31,103	0			
500.00	Grand Total: Decreases		1,107,164	806,749			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150045

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	393,118	0	0	0	1.00
2.00	Land Improvements	1,955,099	13,333	0	13,333	2.00
3.00	Buildings and Fixtures	53,782,651	329,708	0	329,708	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	23,502,531	2,705,635	0	2,705,635	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	79,633,399	3,048,676	0	3,048,676	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	79,633,399	3,048,676	0	3,048,676	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	393,118	0			1.00
2.00	Land Improvements	1,699,338	0			2.00
3.00	Buildings and Fixtures	52,726,620	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	20,948,820	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	75,767,896	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	75,767,896	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150045

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	4,474,810	0	343,043	0	0	1.00
1.01	MAC WEST - NEW	27,858	0	0	0	0	1.01
1.02	NORTH ANNEX - NEW	4,376	0	0	0	0	1.02
1.03	GARRETT CLINIC - NEW	22,078	0	0	0	0	1.03
1.04	BUTLER - NEW	11,572	0	0	0	0	1.04
1.05	MAC EAST - NEW	161,692	0	0	0	0	1.05
1.06	GARRETT LAB - NEW	0	0	0	0	0	1.06
1.07	MEDICAL ARTS - NEW	56,817	0	0	0	0	1.07
1.08	DAY SPRING - NEW	0	0	0	0	0	1.08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,759,203	0	343,043	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	69,935	4,887,788	1.00			
1.01	MAC WEST - NEW	0	27,858	1.01			
1.02	NORTH ANNEX - NEW	0	4,376	1.02			
1.03	GARRETT CLINIC - NEW	0	22,078	1.03			
1.04	BUTLER - NEW	0	11,572	1.04			
1.05	MAC EAST - NEW	0	161,692	1.05			
1.06	GARRETT LAB - NEW	0	0	1.06			
1.07	MEDICAL ARTS - NEW	0	56,817	1.07			
1.08	DAY SPRING - NEW	0	0	1.08			
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00			
3.00	Total (sum of lines 1-2)	69,935	5,172,181	3.00			

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150045

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
1.01	MAC WEST - NEW	0	0	0	0.000000	0	1.01
1.02	NORTH ANNEX - NEW	0	0	0	0.000000	0	1.02
1.03	GARRETT CLINIC - NEW	0	0	0	0.000000	0	1.03
1.04	BUTLER - NEW	0	0	0	0.000000	0	1.04
1.05	MAC EAST - NEW	0	0	0	0.000000	0	1.05
1.06	GARRETT LAB - NEW	0	0	0	0.000000	0	1.06
1.07	MEDICAL ARTS - NEW	0	0	0	0.000000	0	1.07
1.08	DAY SPRING - NEW	0	0	0	0.000000	0	1.08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of col. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,439,951	-343,043	1.00
1.01	MAC WEST - NEW	0	0	0	27,858	0	1.01
1.02	NORTH ANNEX - NEW	0	0	0	4,376	0	1.02
1.03	GARRETT CLINIC - NEW	0	0	0	22,078	0	1.03
1.04	BUTLER - NEW	0	0	0	11,572	0	1.04
1.05	MAC EAST - NEW	0	0	0	161,692	0	1.05
1.06	GARRETT LAB - NEW	0	0	0	0	0	1.06
1.07	MEDICAL ARTS - NEW	0	0	0	56,817	0	1.07
1.08	DAY SPRING - NEW	0	0	0	31,365	0	1.08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,755,709	-343,043	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	343,043	0	0	69,935	4,509,886	1.00
1.01	MAC WEST - NEW	0	0	0	0	27,858	1.01
1.02	NORTH ANNEX - NEW	0	0	0	0	4,376	1.02
1.03	GARRETT CLINIC - NEW	0	0	0	0	22,078	1.03
1.04	BUTLER - NEW	0	0	0	0	11,572	1.04
1.05	MAC EAST - NEW	0	0	0	0	161,692	1.05
1.06	GARRETT LAB - NEW	0	0	0	0	0	1.06
1.07	MEDICAL ARTS - NEW	0	0	0	0	56,817	1.07
1.08	DAY SPRING - NEW	0	0	0	0	31,365	1.08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	343,043	0	0	69,935	4,825,644	3.00

Provider CCN: 150045

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

Worksheet A-8  
Date/Time Prepared:  
2/25/2014 4:27 pm

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-343,043	CAP REL COSTS-BLDG & FIXT	1.00	10	1.00
1.01	Investment income - MAC WEST - NEW (chapter 2)			OMAC WEST - NEW	1.01	0	1.01
1.02	Investment income - NORTH ANNEX - NEW (chapter 2)			ONORTH ANNEX - NEW	1.02	0	1.02
1.03	Investment income - GARRETT CLINIC - NEW (chapter 2)			OGARRETT CLINIC - NEW	1.03	0	1.03
1.04	Investment income - BUTLER - NEW (chapter 2)			OBUTLER - NEW	1.04	0	1.04
1.05	Investment income - MAC EAST - NEW (chapter 2)			OMAC EAST - NEW	1.05	0	1.05
1.06	Investment income - GARRETT LAB - NEW (chapter 2)			OGARRETT LAB - NEW	1.06	0	1.06
1.07	Investment income - MEDICAL ARTS - NEW (chapter 2)			OMEDICAL ARTS - NEW	1.07	0	1.07
1.08	Investment income - DAY SPRING - NEW (chapter 2)			ODAY SPRING - NEW	1.08	0	1.08
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,308,834			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service	B	-1,186	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-231,454	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-47,731	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-646	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			OCAP REL COSTS-BLDG & FIXT	1.00	0	26.00

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
				Cost Center	Line #	
				1.00	2.00	
26.01	Depreciation - MAC WEST - NEW			OMAC WEST - NEW	1.01	0 26.01
26.02	Depreciation - NORTH ANNEX - NEW			ONORTH ANNEX - NEW	1.02	0 26.02
26.03	Depreciation - GARRETT CLINIC - NEW			OGARRETT CLINIC - NEW	1.03	0 26.03
26.04	Depreciation - BUTLER - NEW			OBUTLER - NEW	1.04	0 26.04
26.05	Depreciation - MAC EAST - NEW			OMAC EAST - NEW	1.05	0 26.05
26.06	Depreciation - GARRETT LAB - NEW			OGARRETT LAB - NEW	1.06	0 26.06
26.07	Depreciation - MEDICAL ARTS - NEW			OMEDICAL ARTS - NEW	1.07	0 26.07
26.08	Depreciation - DAY SPRING - NEW			ODAY SPRING - NEW	1.08	0 26.08
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			OCAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00	0 28.00
29.00	Physicians' assistant			0	0.00	0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00	0 30.00
30.99	Hospice (non-distinct) (see instructions)			OADULTS & PEDIATRICS	30.00	0 30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	68.00	0 31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0 32.00
33.00	MISCELLANEOUS INCOME	B	-385	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.00
33.01	MISCELLANEOUS INCOME	B	-102,786	ADMINISTRATIVE & GENERAL	5.00	0 33.01
33.05	WASTE DISPOSAL REVENUE	B	-474	OPERATION OF PLANT	7.00	0 33.05
33.06	MISCELLANEOUS INCOME	B	-733	OPERATION OF PLANT	7.00	0 33.06
33.07	HOUSEKEEPING INCOME	B	-8,117	HOUSEKEEPING	9.00	0 33.07
33.08	OBSTETRICS MISCELLANEOUS INCOME	B	-1,605	ADULTS & PEDIATRICS	30.00	0 33.08
33.09	RADIOLOGY NON-PATIENT REVENUE	B	-357	RADIOLOGY-DIAGNOSTIC	54.00	0 33.09
33.10	NON-PATIENT LAB REVENUE	B	-34,862	LABORATORY	60.00	0 33.10
33.11	MISCELLANEOUS INCOME	B	-17,076	CARDIAC REHAB	66.01	0 33.11
33.12	MISCELLANEOUS INCOME	B	-4,544	DRUGS CHARGED TO PATIENTS	73.00	0 33.12
33.13	AMBULANCE SERVICE REVENUE	B	-50,220	AMBULANCE SERVICES	95.00	0 33.13
33.14	AMBULANCE SUBSIDY	B	-369,697	AMBULANCE SERVICES	95.00	0 33.14
33.15	DIABETES SERVICE MISCELLANEOUS INCOME	B	-4,279	DIETARY	10.00	0 33.15
33.16	HOME HEALTH MISCELLANEOUS INCOME	B	-40,048	HOME HEALTH AGENCY	101.00	0 33.16
33.17	HOSPICE MISCELLANEOUS INCOME	B	-200	HOSPICE	116.00	0 33.17
33.18	LOBBYING PORTION OF IHA & AHA DUES	A	-5,930	ADMINISTRATIVE & GENERAL	5.00	0 33.18
33.19	LOBBYING PORTION OF IAHC DUES - HOS	A	-73	HOSPICE	116.00	0 33.19
33.20	LOBBYING PORTION OF IAHC DUES - HHA	A	-109	HOME HEALTH AGENCY	101.00	0 33.20
33.21	NON-ALLOWABLE MARKETING	A	-1,818	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.21
33.23	NON-ALLOWABLE MARKETING	A	-509,765	ADMINISTRATIVE & GENERAL	5.00	0 33.23
33.24	NON-ALLOWABLE MARKETING	A	-1,793	RADIOLOGY-DIAGNOSTIC	54.00	0 33.24
33.25	NON-ALLOWABLE MARKETING	A	-58,996	PHYSICAL THERAPY	66.00	0 33.25
33.26	NON-ALLOWABLE MARKETING	A	-258	HOME HEALTH AGENCY	101.00	0 33.26
33.27	NON-ALLOWABLE MARKETING	A	-35	HOSPICE	116.00	0 33.27
33.28	NON-ALLOWABLE MARKETING	A	-480	DEKALB MEDICAL SERVICES	192.01	0 33.28
33.29	LIFELINE EXPENSES	A	-30,699	HOME HEALTH AGENCY	101.00	0 33.29
33.31	LIFELINE EXPENSES - DEPRECIATION	A	-3,494	CAP REL COSTS-BLDG & FIXT	1.00	9 33.31
33.32	FLOWER/GIFTS	A	-4,812	ADMINISTRATIVE & GENERAL	5.00	0 33.32
33.33	SELF-INSURANCE EXPENSES	A	-643,478	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.33
33.35	CHRISTMAS PARTY & OPEN HOUSE	A	-4,577	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.35
33.37	PHYSICIAN RECRUITMENT	A	-100,671	ADMINISTRATIVE & GENERAL	5.00	0 33.37
33.38	THERAPY MISCELLANEOUS REVENUE	A	-4,478	PHYSICAL THERAPY	66.00	0 33.38
33.39	HAF FEE	A	-2,192,311	ADMINISTRATIVE & GENERAL	5.00	0 33.39
33.40	SNACK BAR	A	-76,048	SNACK BAR	10.01	0 33.40
33.41			0		0.00	0 33.41
33.42			0		0.00	0 33.42
33.43			0		0.00	0 33.43

Provider CCN: 150045

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

Worksheet A-8

Date/Time Prepared:  
 2/25/2014 4:27 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
	1.00	2.00	3.00	4.00	5.00	
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,208,102				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150045

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

Worksheet A-8-2

Date/Time Prepared:  
2/25/2014 4:27 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	100,008	0	100,008	177,200	1,014	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	15,563	0	15,563	177,200	125	2.00
3.00	31.00	INTENSIVE CARE UNIT	6,000	6,000	0	177,200	0	3.00
4.00	50.00	OPERATING ROOM	848,158	848,158	0	177,200	0	4.00
5.00	50.00	OPERATING ROOM	2,250	2,250	0	177,200	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	30,695	30,695	0	177,200	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	1,113	1,113	0	177,200	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	117,354	0	117,354	177,200	1,658	8.00
9.00	69.00	ELECTROCARDIOLOGY	14,810	14,810	0	177,200	0	9.00
10.00	91.00	EMERGENCY	387,271	387,271	0	177,200	0	10.00
200.00			1,523,222	1,290,297	232,925		2,797	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	86,385	4,319	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	10,649	532	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	141,249	7,062	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			238,283	11,913	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	86,385	13,623	13,623		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	10,649	4,914	4,914		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	6,000		3.00
4.00	50.00	OPERATING ROOM	0	0	0	848,158		4.00
5.00	50.00	OPERATING ROOM	0	0	0	2,250		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	30,695		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,113		7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	141,249	0	0		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	14,810		9.00
10.00	91.00	EMERGENCY	0	0	0	387,271		10.00
200.00			0	238,283	18,537	1,308,834		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150045

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
		BLDG & FIXT	MAC WEST - NEW	NORTH ANNEX - NEW	GARRETT CLINIC - NEW	
		1.00	1.01	1.02	1.03	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	4,509,886	4,509,886			1.00
1.01 00101	MAC WEST - NEW	27,858	0	27,858		1.01
1.02 00102	NORTH ANNEX - NEW	4,376	0	0	4,376	1.02
1.03 00103	GARRETT CLINIC - NEW	22,078	0	0	0	22,078
1.04 00104	BUTLER - NEW	11,572	0	0	0	0
1.05 00105	MAC EAST - NEW	161,692	0	0	0	0
1.06 00106	GARRETT LAB - NEW	0	0	0	0	0
1.07 00107	MEDICAL ARTS - NEW	56,817	0	0	0	0
1.08 00108	DAY SPRING - NEW	31,365	0	0	0	0
2.00 00200	CAP REL COSTS-MVBLE EQUIP	0				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,060,985	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	7,395,876	234,455	0	1,791	5.00
7.00 00700	OPERATION OF PLANT	1,683,456	1,994,176	4,999	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	252,780	29,695	0	0	8.00
9.00 00900	HOUSEKEEPING	847,770	47,229	0	0	9.00
10.00 01000	DIETARY	266,245	24,920	0	0	10.00
10.01 01001	SNACK BAR	0	0	0	0	10.01
11.00 01100	CAFETERIA	496,749	58,620	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	767,180	26,363	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	429,478	31,312	0	0	14.00
15.00 01500	PHARMACY	934,509	28,800	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	622,252	69,513	0	0	16.00
17.00 01700	SOCIAL SERVICE	73,066	4,079	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	2,423,270	291,633	0	0	30.00
31.00 03100	INTENSIVE CARE UNIT	1,179,457	123,831	0	0	31.00
43.00 04300	NURSERY	310,174	40,191	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	2,373,314	441,229	0	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	617,602	122,562	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,794,718	231,670	0	0	54.00
60.00 06000	LABORATORY	3,567,728	106,048	1,132	0	4,616
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	526,244	27,159	0	0	65.00
66.00 06600	PHYSICAL THERAPY	1,034,430	129,725	0	0	66.00
66.01 06601	CARDIAC REHAB	148,241	68,270	0	0	66.01
69.00 06900	ELECTROCARDIOLOGY	104,049	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	251,743	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	827,203	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	598,620	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,489,631	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	41,025	0	0	0	90.00
91.00 09100	EMERGENCY	1,552,367	183,943	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	1,260,380	67,598	0	0	95.00
99.10 09910	CORF	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	875,549	0	0	2,333	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	314,606	0	0	252	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	43,946,341	4,383,021	6,131	4,376	4,616
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS PRIVATE OFFICES	297,368	126,865	19,839	0	192.00
192.01 19201	DEKALB MEDICAL SERVICES	4,985,154	0	1,888	0	17,462
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	194.00
194.01 07951	ADULT DAY CARE	0	0	0	0	194.01
194.02 07952	FOUNDATION	37,383	0	0	0	194.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118-201)	49,266,246	4,509,886	27,858	4,376	22,078

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150045

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		CAPITAL RELATED COSTS						
		BUTLER - NEW	MAC EAST - NEW	GARRETT LAB - NEW	MEDICAL ARTS - NEW	DAY SPRING - NEW		
		1.04	1.05	1.06	1.07	1.08		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MAC WEST - NEW						1.01
1.02	00102	NORTH ANNEX - NEW						1.02
1.03	00103	GARRETT CLINIC - NEW						1.03
1.04	00104	BUTLER - NEW	11,572					1.04
1.05	00105	MAC EAST - NEW	0	161,692				1.05
1.06	00106	GARRETT LAB - NEW	0	0	0			1.06
1.07	00107	MEDICAL ARTS - NEW	0	0	0	56,817		1.07
1.08	00108	DAY SPRING - NEW	0	0	0	0	31,365	1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	21,652	0	0	31,365	5.00
7.00	00700	OPERATION OF PLANT	0	48,058	0	4,506	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	328	0	0	0	9.00
10.00	01000	DIETARY	0	880	0	0	0	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,225	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	818	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
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	818	72,143	0	4,506	31,365	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	55,853	0	43,366	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	10,754	33,696	0	8,945	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	11,572	161,692	0	56,817	31,365	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150045

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
	MVBLE EQUIP						
	2.00	4.00					
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MAC WEST - NEW					1.01
1.02	00102	NORTH ANNEX - NEW					1.02
1.03	00103	GARRETT CLINIC - NEW					1.03
1.04	00104	BUTLER - NEW					1.04
1.05	00105	MAC EAST - NEW					1.05
1.06	00106	GARRETT LAB - NEW					1.06
1.07	00107	MEDICAL ARTS - NEW					1.07
1.08	00108	DAY SPRING - NEW					1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,060,985			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	394,864	8,080,003	8,080,003	5.00
7.00	00700	OPERATION OF PLANT	0	70,565	3,805,760	746,622	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,168	296,643	58,196	8.00
9.00	00900	HOUSEKEEPING	0	73,430	968,757	190,053	9.00
10.00	01000	DIETARY	0	20,526	312,571	61,321	10.00
10.01	01001	SNACK BAR	0	2,933	2,933	575	10.01
11.00	01100	CAFETERIA	0	43,641	599,010	117,515	11.00
13.00	01300	NURSING ADMINISTRATION	0	89,326	882,869	173,203	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	18,452	479,242	94,019	14.00
15.00	01500	PHARMACY	0	70,800	1,034,109	202,874	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	66,739	759,729	149,045	16.00
17.00	01700	SOCIAL SERVICE	0	8,865	86,010	16,874	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	236,792	2,951,695	579,069	30.00
31.00	03100	INTENSIVE CARE UNIT	0	111,850	1,415,138	277,625	31.00
43.00	04300	NURSERY	0	26,630	376,995	73,960	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	222,495	3,037,038	595,812	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	53,549	793,713	155,712	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	209,094	3,235,482	634,743	54.00
60.00	06000	LABORATORY	0	187,609	3,867,951	758,822	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	631	554,034	108,691	65.00
66.00	06600	PHYSICAL THERAPY	0	38,993	1,203,148	236,036	66.00
66.01	06601	CARDIAC REHAB	0	19,366	235,877	46,275	66.01
69.00	06900	ELECTROCARDIOLOGY	0	10,650	114,699	22,502	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	378	252,121	49,462	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	827,203	162,282	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	598,620	117,438	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,489,631	292,239	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	4,371	45,396	8,906	90.00
91.00	09100	EMERGENCY	0	156,616	1,892,926	371,358	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	152,759	1,480,737	290,494	95.00
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	95,106	972,988	190,883	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	23,374	338,232	66,355	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,424,572	42,991,260	6,848,961	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	21,872	565,163	110,875	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	611,573	5,669,472	1,112,251	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	2,968	40,351	7,916	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	3,060,985	49,266,246	8,080,003	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150045

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	SNACK BAR	CAFETERIA	
		8.00	9.00	10.00	10.01	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MAC WEST - NEW					1.01
1.02	00102	NORTH ANNEX - NEW					1.02
1.03	00103	GARRETT CLINIC - NEW					1.03
1.04	00104	BUTLER - NEW					1.04
1.05	00105	MAC EAST - NEW					1.05
1.06	00106	GARRETT LAB - NEW					1.06
1.07	00107	MEDICAL ARTS - NEW					1.07
1.08	00108	DAY SPRING - NEW					1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	391,959				8.00
9.00	00900	HOUSEKEEPING	20,269	1,240,791			9.00
10.00	01000	DIETARY	0	10,446	421,831		10.00
10.01	01001	SNACK BAR	0	0	0	3,508	10.01
11.00	01100	CAFETERIA	0	20,415	0	3,508	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,181	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,905	0	0	14.00
15.00	01500	PHARMACY	0	10,030	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,669	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,421	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	143,729	101,566	316,182	0	100,416
31.00	03100	INTENSIVE CARE UNIT	39,306	43,126	105,649	0	44,248
43.00	04300	NURSERY	7,458	13,997	0	0	8,767
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	55,955	153,665	0	0	74,503
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	42,684	0	0	17,644
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,691	80,683	0	0	71,710
60.00	06000	LABORATORY	0	52,524	0	0	77,517
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	4,479	9,458	0	0	111
66.00	06600	PHYSICAL THERAPY	7,304	45,179	0	0	16,870
66.01	06601	CARDIAC REHAB	1,039	23,776	0	0	8,850
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	4,840
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	83
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	1,345	0	0	0	1,825
91.00	09100	EMERGENCY	58,718	66,460	0	0	56,499
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	7,667	23,542	0	0	72,539
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	24,010	0	0	36,588
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	77	2,598	0	0	7,550
118.00		SUBTOTALS (SUM OF LINES 1-117)	385,037	772,335	421,831	3,508	694,449
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	313,769	0	0	18,031
192.01	19201	DEKALB MEDICAL SERVICES	6,922	154,687	0	0	101,245
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0
194.01	07951	ADULT DAY CARE	0	0	0	0	0
194.02	07952	FOUNDATION	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	391,959	1,240,791	421,831	3,508	813,725

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150045

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00104						1.04
1.05	00105						1.05
1.06	00106						1.06
1.07	00107						1.07
1.08	00108						1.08
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
10.01	01001						10.01
11.00	01100						11.00
13.00	01300	1,122,129					13.00
14.00	01400	35,444	670,421				14.00
15.00	01500	0	0	1,299,856			15.00
16.00	01600	0	0	0	1,069,717		16.00
17.00	01700	8,840	0	0	0	121,148	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	304,841	0	0	99,517	121,148	30.00
31.00	03100	134,301	0	0	46,838	0	31.00
43.00	04300	26,645	0	0	10,325	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	226,178	0	0	222,970	0	50.00
52.00	05200	53,580	0	0	20,763	0	52.00
54.00	05400	0	0	0	205,866	0	54.00
60.00	06000	21,131	0	0	184,965	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	0	0	23,295	0	65.00
66.00	06600	0	0	0	31,428	0	66.00
66.01	06601	0	0	0	3,627	0	66.01
69.00	06900	0	0	0	9,247	0	69.00
70.00	07000	0	0	0	13,943	0	70.00
71.00	07100	0	670,421	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	1,299,856	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	5,578	0	0	1,628	0	90.00
91.00	09100	171,529	0	0	101,831	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	111,111	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
116.00	11600	22,951	0	0	8,394	0	116.00
118.00		1,122,129	670,421	1,299,856	984,637	121,148	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	85,080	0	192.01
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,122,129	670,421	1,299,856	1,069,717	121,148	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150045

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
1.01	00101				1.01
1.02	00102				1.02
1.03	00103				1.03
1.04	00104				1.04
1.05	00105				1.05
1.06	00106				1.06
1.07	00107				1.07
1.08	00108				1.08
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
10.01	01001				10.01
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	5,082,712	0	5,082,712	30.00
31.00	03100	2,261,023	0	2,261,023	31.00
43.00	04300	568,387	0	568,387	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	4,917,670	0	4,917,670	50.00
52.00	05200	1,237,302	0	1,237,302	52.00
54.00	05400	4,555,768	0	4,555,768	54.00
60.00	06000	5,151,433	0	5,151,433	60.00
60.01	06001	0	0	0	60.01
65.00	06500	734,017	0	734,017	65.00
66.00	06600	1,702,125	0	1,702,125	66.00
66.01	06601	404,783	0	404,783	66.01
69.00	06900	151,288	0	151,288	69.00
70.00	07000	315,609	0	315,609	70.00
71.00	07100	1,659,906	0	1,659,906	71.00
72.00	07200	716,058	0	716,058	72.00
73.00	07300	3,081,726	0	3,081,726	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	64,678	0	64,678	90.00
91.00	09100	2,957,866	0	2,957,866	91.00
92.00	09200		0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	1,959,479	0	1,959,479	95.00
99.10	09910	0	0	0	99.10
101.00	10100	1,421,758	0	1,421,758	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
116.00	11600	455,484	0	455,484	116.00
118.00		39,399,072	0	39,399,072	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	0	0	0	190.00
191.00	19100	0	0	0	191.00
192.00	19200	2,134,033	0	2,134,033	192.00
192.01	19201	7,684,874	0	7,684,874	192.01
193.00	19300	0	0	0	193.00
194.00	07950	0	0	0	194.00
194.01	07951	0	0	0	194.01
194.02	07952	48,267	0	48,267	194.02
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		49,266,246	0	49,266,246	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150045

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			BLDG & FIXT	MAC WEST - NEW	NORTH ANNEX - NEW	GARRETT CLINIC - NEW	
			0	1.00	1.01	1.02	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MAC WEST - NEW					1.01
1.02	00102	NORTH ANNEX - NEW					1.02
1.03	00103	GARRETT CLINIC - NEW					1.03
1.04	00104	BUTLER - NEW					1.04
1.05	00105	MAC EAST - NEW					1.05
1.06	00106	GARRETT LAB - NEW					1.06
1.07	00107	MEDICAL ARTS - NEW					1.07
1.08	00108	DAY SPRING - NEW					1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	234,455	0	1,791	0
7.00	00700	OPERATION OF PLANT	0	1,994,176	4,999	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	29,695	0	0	0
9.00	00900	HOUSEKEEPING	0	47,229	0	0	0
10.00	01000	DIETARY	0	24,920	0	0	0
10.01	01001	SNACK BAR	0	0	0	0	0
11.00	01100	CAFETERIA	0	58,620	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	26,363	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	31,312	0	0	0
15.00	01500	PHARMACY	0	28,800	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	69,513	0	0	0
17.00	01700	SOCIAL SERVICE	0	4,079	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	291,633	0	0	0
31.00	03100	INTENSIVE CARE UNIT	0	123,831	0	0	0
43.00	04300	NURSERY	0	40,191	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	441,229	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	122,562	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	231,670	0	0	0
60.00	06000	LABORATORY	0	106,048	1,132	0	4,616
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	27,159	0	0	0
66.00	06600	PHYSICAL THERAPY	0	129,725	0	0	0
66.01	06601	CARDIAC REHAB	0	68,270	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	183,943	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	67,598	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	2,333	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	252	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,383,021	6,131	4,376	4,616
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	126,865	19,839	0	0
192.01	19201	DEKALB MEDICAL SERVICES	0	0	1,888	0	17,462
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0
194.01	07951	ADULT DAY CARE	0	0	0	0	0
194.02	07952	FOUNDATION	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118-201)	0	4,509,886	27,858	4,376	22,078

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150045

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		CAPITAL RELATED COSTS						
		BUTLER - NEW	MAC EAST - NEW	GARRETT LAB - NEW	MEDICAL ARTS - NEW	DAY SPRING - NEW		
		1.04	1.05	1.06	1.07	1.08		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MAC WEST - NEW						1.01
1.02	00102	NORTH ANNEX - NEW						1.02
1.03	00103	GARRETT CLINIC - NEW						1.03
1.04	00104	BUTLER - NEW						1.04
1.05	00105	MAC EAST - NEW						1.05
1.06	00106	GARRETT LAB - NEW						1.06
1.07	00107	MEDICAL ARTS - NEW						1.07
1.08	00108	DAY SPRING - NEW						1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	21,652	0	0	31,365	5.00
7.00	00700	OPERATION OF PLANT	0	48,058	0	4,506	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	328	0	0	0	9.00
10.00	01000	DIETARY	0	880	0	0	0	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,225	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	818	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
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	818	72,143	0	4,506	31,365	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	55,853	0	43,366	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	10,754	33,696	0	8,945	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	11,572	161,692	0	56,817	31,365	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150045

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
	MVBLE EQUIP						
	2.00	2A					
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MAC WEST - NEW					1.01
1.02	00102	NORTH ANNEX - NEW					1.02
1.03	00103	GARRETT CLINIC - NEW					1.03
1.04	00104	BUTLER - NEW					1.04
1.05	00105	MAC EAST - NEW					1.05
1.06	00106	GARRETT LAB - NEW					1.06
1.07	00107	MEDICAL ARTS - NEW					1.07
1.08	00108	DAY SPRING - NEW					1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	289,263	0	289,263	5.00
7.00	00700	OPERATION OF PLANT	0	2,051,739	0	26,728	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	29,695	0	2,083	8.00
9.00	00900	HOUSEKEEPING	0	47,557	0	6,804	9.00
10.00	01000	DIETARY	0	25,800	0	2,195	10.00
10.01	01001	SNACK BAR	0	0	0	21	10.01
11.00	01100	CAFETERIA	0	58,620	0	4,207	11.00
13.00	01300	NURSING ADMINISTRATION	0	26,363	0	6,200	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	31,312	0	3,366	14.00
15.00	01500	PHARMACY	0	28,800	0	7,263	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	70,738	0	5,336	16.00
17.00	01700	SOCIAL SERVICE	0	4,079	0	604	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	291,633	0	20,730	30.00
31.00	03100	INTENSIVE CARE UNIT	0	123,831	0	9,939	31.00
43.00	04300	NURSERY	0	40,191	0	2,648	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	441,229	0	21,329	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	122,562	0	5,574	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	231,670	0	22,723	54.00
60.00	06000	LABORATORY	0	112,614	0	27,165	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	27,159	0	3,891	65.00
66.00	06600	PHYSICAL THERAPY	0	129,725	0	8,450	66.00
66.01	06601	CARDIAC REHAB	0	68,270	0	1,657	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	806	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,771	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	5,809	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,204	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,462	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	319	90.00
91.00	09100	EMERGENCY	0	183,943	0	13,294	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	67,598	0	10,399	95.00
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	2,333	0	6,833	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	252	0	2,375	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,506,976	0	245,185	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	245,923	0	3,969	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	72,745	0	39,826	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	283	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	4,825,644	0	289,263	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150045

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	SNACK BAR	CAFETERIA	
		8.00	9.00	10.00	10.01	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MAC WEST - NEW					1.01
1.02	00102	NORTH ANNEX - NEW					1.02
1.03	00103	GARRETT CLINIC - NEW					1.03
1.04	00104	BUTLER - NEW					1.04
1.05	00105	MAC EAST - NEW					1.05
1.06	00106	GARRETT LAB - NEW					1.06
1.07	00107	MEDICAL ARTS - NEW					1.07
1.08	00108	DAY SPRING - NEW					1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	48,726				8.00
9.00	00900	HOUSEKEEPING	2,520	85,056			9.00
10.00	01000	DIETARY	0	716	45,829		10.00
10.01	01001	SNACK BAR	0	0	0	21	10.01
11.00	01100	CAFETERIA	0	1,399	0	21	97,703
13.00	01300	NURSING ADMINISTRATION	0	629	0	0	2,872
14.00	01400	CENTRAL SERVICES & SUPPLY	0	748	0	0	1,401
15.00	01500	PHARMACY	0	688	0	0	2,022
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,828	0	0	4,629
17.00	01700	SOCIAL SERVICE	0	97	0	0	349
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	17,867	6,962	34,351	0	12,057
31.00	03100	INTENSIVE CARE UNIT	4,886	2,956	11,478	0	5,313
43.00	04300	NURSERY	927	960	0	0	1,053
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	6,956	10,534	0	0	8,945
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,926	0	0	2,118
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,686	5,531	0	0	8,610
60.00	06000	LABORATORY	0	3,601	0	0	9,307
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	557	648	0	0	13
66.00	06600	PHYSICAL THERAPY	908	3,097	0	0	2,026
66.01	06601	CARDIAC REHAB	129	1,630	0	0	1,063
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	581
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	167	0	0	0	219
91.00	09100	EMERGENCY	7,299	4,556	0	0	6,784
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	953	1,614	0	0	8,710
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	1,646	0	0	4,393
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	10	178	0	0	907
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,865	52,944	45,829	21	83,382
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	21,508	0	0	2,165
192.01	19201	DEKALB MEDICAL SERVICES	861	10,604	0	0	12,156
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0
194.01	07951	ADULT DAY CARE	0	0	0	0	0
194.02	07952	FOUNDATION	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	48,726	85,056	45,829	21	97,703

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150045

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00104						1.04
1.05	00105						1.05
1.06	00106						1.06
1.07	00107						1.07
1.08	00108						1.08
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
10.01	01001						10.01
11.00	01100						11.00
13.00	01300	51,110					13.00
14.00	01400	1,614	56,311				14.00
15.00	01500	0	0	55,210			15.00
16.00	01600	0	0	0	126,235		16.00
17.00	01700	403	0	0	0	7,860	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	13,885	0	0	11,744	7,860	30.00
31.00	03100	6,117	0	0	5,527	0	31.00
43.00	04300	1,214	0	0	1,218	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	10,302	0	0	26,312	0	50.00
52.00	05200	2,440	0	0	2,450	0	52.00
54.00	05400	0	0	0	24,294	0	54.00
60.00	06000	962	0	0	21,828	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	0	0	2,749	0	65.00
66.00	06600	0	0	0	3,709	0	66.00
66.01	06601	0	0	0	428	0	66.01
69.00	06900	0	0	0	1,091	0	69.00
70.00	07000	0	0	0	1,645	0	70.00
71.00	07100	0	56,311	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	55,210	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	254	0	0	192	0	90.00
91.00	09100	7,813	0	0	12,017	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	5,061	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
116.00	11600	1,045	0	0	991	0	116.00
118.00		51,110	56,311	55,210	116,195	7,860	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	10,040	0	192.01
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		51,110	56,311	55,210	126,235	7,860	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150045

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
1.01	00101				1.01
1.02	00102				1.02
1.03	00103				1.03
1.04	00104				1.04
1.05	00105				1.05
1.06	00106				1.06
1.07	00107				1.07
1.08	00108				1.08
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
10.01	01001				10.01
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	583,530	0	583,530	30.00
31.00	03100	240,720	0	240,720	31.00
43.00	04300	71,149	0	71,149	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	777,426	0	777,426	50.00
52.00	05200	208,019	0	208,019	52.00
54.00	05400	429,733	0	429,733	54.00
60.00	06000	261,550	0	261,550	60.00
60.01	06001	0	0	0	60.01
65.00	06500	50,517	0	50,517	65.00
66.00	06600	221,952	0	221,952	66.00
66.01	06601	112,140	0	112,140	66.01
69.00	06900	2,478	0	2,478	69.00
70.00	07000	3,426	0	3,426	70.00
71.00	07100	62,120	0	62,120	71.00
72.00	07200	4,204	0	4,204	72.00
73.00	07300	65,672	0	65,672	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	1,151	0	1,151	90.00
91.00	09100	344,618	0	344,618	91.00
92.00	09200		0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	127,854	0	127,854	95.00
99.10	09910	0	0	0	99.10
101.00	10100	59,612	0	59,612	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
116.00	11600	10,016	0	10,016	116.00
118.00		3,637,887	0	3,637,887	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	0	0	0	190.00
191.00	19100	0	0	0	191.00
192.00	19200	787,748	0	787,748	192.00
192.01	19201	399,726	0	399,726	192.01
193.00	19300	0	0	0	193.00
194.00	07950	0	0	0	194.00
194.01	07951	0	0	0	194.01
194.02	07952	283	0	283	194.02
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		4,825,644	0	4,825,644	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045

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

Worksheet B-1  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		CAPITAL RELATED COSTS						
		BLDG & FIXT (SQUARE FEET)	MAC WEST - NEW (SQUARE FEET)	NORTH ANNEX - NEW (SQUARE FEET)	GARRETT CLINIC - NEW (SQUARE FEET)	BUTLER - NEW (SQUARE FEET)		
		1.00	1.01	1.02	1.03	1.04		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT	181,334					1.00
1.01	00101	MAC WEST - NEW	0	16,334				1.01
1.02	00102	NORTH ANNEX - NEW	0	0	5,200			1.02
1.03	00103	GARRETT CLINIC - NEW	0	0	0	3,750		1.03
1.04	00104	BUTLER - NEW	0	0	0	0	4,977	1.04
1.05	00105	MAC EAST - NEW	0	0	0	0	0	1.05
1.06	00106	GARRETT LAB - NEW	0	0	0	0	0	1.06
1.07	00107	MEDICAL ARTS - NEW	0	0	0	0	0	1.07
1.08	00108	DAY SPRING - NEW	0	0	0	0	0	1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,427	0	2,128	0	0	5.00
7.00	00700	OPERATION OF PLANT	80,182	2,931	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,194	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,899	0	0	0	0	9.00
10.00	01000	DIETARY	1,002	0	0	0	0	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	2,357	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,060	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,259	0	0	0	0	14.00
15.00	01500	PHARMACY	1,158	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,795	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	164	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	11,726	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,979	0	0	0	0	31.00
43.00	04300	NURSERY	1,616	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	17,741	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,928	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,315	0	0	0	0	54.00
60.00	06000	LABORATORY	4,264	664	0	784	352	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,092	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,216	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	2,745	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,396	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	2,718	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	2,772	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	300	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	176,233	3,595	5,200	784	352	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	5,101	11,632	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	1,107	0	2,966	4,625	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,509,886	27,858	4,376	22,078	11,572	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.870603	1.705522	0.841538	5.887467	2.325095	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045

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

Worksheet B-1

Date/Time Prepared:  
2/25/2014 4:27 pm

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045

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

Worksheet B-1

Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		CAPITAL RELATED COSTS					2.00	
		MAC EAST - NEW	GARRETT LAB - NEW	MEDICAL ARTS - NEW	DAY SPRING - NEW	MVBLE EQUIP (SQUARE FEET)		
		(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)		
		1.05	1.06	1.07	1.08			
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	MAC WEST - NEW					1.01	
1.02	00102	NORTH ANNEX - NEW					1.02	
1.03	00103	GARRETT CLINIC - NEW					1.03	
1.04	00104	BUTLER - NEW					1.04	
1.05	00105	MAC EAST - NEW	37,481				1.05	
1.06	00106	GARRETT LAB - NEW	0	0			1.06	
1.07	00107	MEDICAL ARTS - NEW	0	0	8,575		1.07	
1.08	00108	DAY SPRING - NEW	0	0	0	18,456	1.08	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					181,334	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	
5.00	00500	ADMINISTRATIVE & GENERAL	5,019	0	0	18,456	9,427	
7.00	00700	OPERATION OF PLANT	11,140	0	680	0	80,182	
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	1,194	
9.00	00900	HOUSEKEEPING	76	0	0	0	1,899	
10.00	01000	DIETARY	204	0	0	0	1,002	
10.01	01001	SNACK BAR	0	0	0	0	0	
11.00	01100	CAFETERIA	0	0	0	0	2,357	
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	1,060	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	1,259	
15.00	01500	PHARMACY	0	0	0	0	1,158	
16.00	01600	MEDICAL RECORDS & LIBRARY	284	0	0	0	2,795	
17.00	01700	SOCIAL SERVICE	0	0	0	0	164	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	11,726	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	4,979	
43.00	04300	NURSERY	0	0	0	0	1,616	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	17,741	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	4,928	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	9,315	
60.00	06000	LABORATORY	0	0	0	0	4,264	
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	1,092	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	5,216	
66.01	06601	CARDIAC REHAB	0	0	0	0	2,745	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	
91.00	09100	EMERGENCY	0	0	0	0	7,396	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0	
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	2,718	
99.10	09910	CORF	0	0	0	0	0	
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						
116.00	11600	HOSPICE	0	0	0	0	0	
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,723	0	680	18,456	176,233	
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	
191.00	19100	RESEARCH	0	0	0	0	0	
192.00	19200	PHYSICIANS PRIVATE OFFICES	12,947	0	6,545	0	5,101	
192.01	19201	DEKALB MEDICAL SERVICES	7,811	0	1,350	0	0	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	
194.01	07951	ADULT DAY CARE	0	0	0	0	0	
194.02	07952	FOUNDATION	0	0	0	0	0	
200.00		Cross Foot Adjustments						
201.00		Negative Cost Centers						
202.00		Cost to be allocated (per Wkst. B, Part I)	161,692	0	56,817	31,365	0	
203.00		Unit cost multiplier (Wkst. B, Part I)	4.313972	0.000000	6.625889	1.699447	0.000000	
204.00		Cost to be allocated (per Wkst. B, Part II)						

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045

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

Worksheet B-1

Date/Time Prepared:  
2/25/2014 4:27 pm

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045

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

Worksheet B-1

Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT (UNADJUSTED SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			4.00	5A	5.00	7.00	8.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MAC WEST - NEW						1.01
1.02	00102	NORTH ANNEX - NEW						1.02
1.03	00103	GARRETT CLINIC - NEW						1.03
1.04	00104	BUTLER - NEW						1.04
1.05	00105	MAC EAST - NEW						1.05
1.06	00106	GARRETT LAB - NEW						1.06
1.07	00107	MEDICAL ARTS - NEW						1.07
1.08	00108	DAY SPRING - NEW						1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	23,123,230					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,982,874	-8,080,003	41,186,243			5.00
7.00	00700	OPERATION OF PLANT	533,060	0	3,805,760	146,431		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	107,024	0	296,643	1,194	353,209	8.00
9.00	00900	HOUSEKEEPING	554,703	0	968,757	1,985	18,265	9.00
10.00	01000	DIETARY	155,060	0	312,571	1,206	0	10.00
10.01	01001	SNACK BAR	22,160	0	2,933	0	0	10.01
11.00	01100	CAFETERIA	329,672	0	599,010	2,357	0	11.00
13.00	01300	NURSING ADMINISTRATION	674,783	0	882,869	1,060	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	139,388	0	479,242	1,259	0	14.00
15.00	01500	PHARMACY	534,833	0	1,034,109	1,158	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	504,160	0	759,729	3,079	0	16.00
17.00	01700	SOCIAL SERVICE	66,968	0	86,010	164	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,788,767	0	2,951,695	11,726	129,520	30.00
31.00	03100	INTENSIVE CARE UNIT	844,939	0	1,415,138	4,979	35,420	31.00
43.00	04300	NURSERY	201,165	0	376,995	1,616	6,721	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,680,768	0	3,037,038	17,741	50,423	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	404,521	0	793,713	4,928	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,579,531	0	3,235,482	9,315	33,965	54.00
60.00	06000	LABORATORY	1,417,229	0	3,867,951	6,064	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	4,768	0	554,034	1,092	4,036	65.00
66.00	06600	PHYSICAL THERAPY	294,560	0	1,203,148	5,216	6,582	66.00
66.01	06601	CARDIAC REHAB	146,296	0	235,877	2,745	936	66.01
69.00	06900	ELECTROCARDIOLOGY	80,454	0	114,699	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,854	0	252,121	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	827,203	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	598,620	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,489,631	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	33,023	0	45,396	0	1,212	90.00
91.00	09100	EMERGENCY	1,183,108	0	1,892,926	7,673	52,913	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	1,153,969	0	1,480,737	2,718	6,909	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	718,451	0	972,988	2,772	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	176,569	0	338,232	300	69	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,315,657	-8,080,003	34,911,257	92,347	346,971	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	165,228	0	565,163	36,225	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	4,619,922	0	5,669,472	17,859	6,238	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	22,423	0	40,351	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,060,985		8,080,003	4,552,382	391,959	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.132377		0.196182	31.088922	1.109708	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		289,263	2,078,467	48,726	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045

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

Worksheet B-1

Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT (UNADJUSTED SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		4.00	5A	5.00	7.00	8.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000		0.007023	14.194173	0.137952	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045

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

Worksheet B-1

Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	SNACK BAR (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION  (DIRECT NRS ING)	
		9.00	10.00	10.01	11.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00104						1.04
1.05	00105						1.05
1.06	00106						1.06
1.07	00107						1.07
1.08	00108						1.08
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	143,252					9.00
10.00	01000	1,206	20,934				10.00
10.01	01001	0	0	1			10.01
11.00	01100	2,357	0	1	29,424		11.00
13.00	01300	1,060	0	0	865	277,999	13.00
14.00	01400	1,259	0	0	422	8,781	14.00
15.00	01500	1,158	0	0	609	0	15.00
16.00	01600	3,079	0	0	1,394	0	16.00
17.00	01700	164	0	0	105	2,190	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	11,726	15,691	0	3,631	75,522	30.00
31.00	03100	4,979	5,243	0	1,600	33,272	31.00
43.00	04300	1,616	0	0	317	6,601	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	17,741	0	0	2,694	56,034	50.00
52.00	05200	4,928	0	0	638	13,274	52.00
54.00	05400	9,315	0	0	2,593	0	54.00
60.00	06000	6,064	0	0	2,803	5,235	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	1,092	0	0	4	0	65.00
66.00	06600	5,216	0	0	610	0	66.00
66.01	06601	2,745	0	0	320	0	66.01
69.00	06900	0	0	0	175	0	69.00
70.00	07000	0	0	0	3	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	66	1,382	90.00
91.00	09100	7,673	0	0	2,043	42,495	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	2,718	0	0	2,623	0	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	2,772	0	0	1,323	27,527	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
116.00	11600	300	0	0	273	5,686	116.00
118.00		89,168	20,934	1	25,111	277,999	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	36,225	0	0	652	0	192.00
192.01	19201	17,859	0	0	3,661	0	192.01
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00							201.00
202.00		1,240,791	421,831	3,508	813,725	1,122,129	202.00
203.00		8.661596	20.150521	3,508.000000	27.655145	4.036450	203.00
204.00		85,056	45,829	21	97,703	51,110	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045

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

Worksheet B-1

Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	SNACK BAR (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION  (DIRECT NRS ING)	
		9.00	10.00	10.01	11.00	13.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.593751	2.189214	21.000000	3.320521	0.183850	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045

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

Worksheet B-1

Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	
		14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
1.01	00101					1.01
1.02	00102					1.02
1.03	00103					1.03
1.04	00104					1.04
1.05	00105					1.05
1.06	00106					1.06
1.07	00107					1.07
1.08	00108					1.08
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
10.01	01001					10.01
11.00	01100					11.00
13.00	01300					13.00
14.00	01400	100				14.00
15.00	01500	0	100			15.00
16.00	01600	0	0	98,546,674		16.00
17.00	01700	0	0	0	100	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	0	0	9,167,819	100	30.00
31.00	03100	0	0	4,314,902	0	31.00
43.00	04300	0	0	951,197	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	0	0	20,541,428	0	50.00
52.00	05200	0	0	1,912,757	0	52.00
54.00	05400	0	0	18,965,112	0	54.00
60.00	06000	0	0	17,039,619	0	60.00
60.01	06001	0	0	0	0	60.01
65.00	06500	0	0	2,146,013	0	65.00
66.00	06600	0	0	2,895,297	0	66.00
66.01	06601	0	0	334,110	0	66.01
69.00	06900	0	0	851,845	0	69.00
70.00	07000	0	0	1,284,470	0	70.00
71.00	07100	100	0	0	0	71.00
72.00	07200	0	0	0	0	72.00
73.00	07300	0	100	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	0	0	149,974	0	90.00
91.00	09100	0	0	9,381,001	0	91.00
92.00	09200	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	0	0	0	0	95.00
99.10	09910	0	0	0	0	99.10
101.00	10100	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	0	0	0	0	113.00
116.00	11600	0	0	773,260	0	116.00
118.00		100	100	90,708,804	100	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	0	0	0	190.00
191.00	19100	0	0	0	0	191.00
192.00	19200	0	0	0	0	192.00
192.01	19201	0	0	7,837,870	0	192.01
193.00	19300	0	0	0	0	193.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	0	0	0	194.02
200.00						200.00
201.00						201.00
202.00		670,421	1,299,856	1,069,717	121,148	202.00
203.00		6,704.210000	12,998.560000	0.010855	1,211.480000	203.00
204.00		56,311	55,210	126,235	7,860	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045

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

Worksheet B-1

Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)		
		14.00	15.00	16.00	17.00		
205.00	Unit cost multiplier (Wkst. B, Part II)	563.110000	552.100000	0.001281	78.600000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150045

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

Worksheet C  
Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	5,082,712		5,082,712	0	5,082,712 30.00	
31.00	03100 INTENSIVE CARE UNIT	2,261,023		2,261,023	0	2,261,023 31.00	
43.00	04300 NURSERY	568,387		568,387	0	568,387 43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	4,917,670		4,917,670	0	4,917,670 50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,237,302		1,237,302	0	1,237,302 52.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,555,768		4,555,768	0	4,555,768 54.00	
60.00	06000 LABORATORY	5,151,433		5,151,433	0	5,151,433 60.00	
60.01	06001 BLOOD LABORATORY	0		0	0	0 60.01	
65.00	06500 RESPIRATORY THERAPY	734,017	0	734,017	0	734,017 65.00	
66.00	06600 PHYSICAL THERAPY	1,702,125	0	1,702,125	0	1,702,125 66.00	
66.01	06601 CARDIAC REHAB	404,783	0	404,783	0	404,783 66.01	
69.00	06900 ELECTROCARDIOLOGY	151,288		151,288	0	151,288 69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	315,609		315,609	0	315,609 70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1,659,906		1,659,906	0	1,659,906 71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	716,058		716,058	0	716,058 72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	3,081,726		3,081,726	0	3,081,726 73.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	64,678		64,678	0	64,678 90.00	
91.00	09100 EMERGENCY	2,957,866		2,957,866	0	2,957,866 91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	744,694		744,694	0	744,694 92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	1,959,479		1,959,479	0	1,959,479 95.00	
99.10	09910 CORF	0		0	0	0 99.10	
101.00	10100 HOME HEALTH AGENCY	1,421,758		1,421,758	0	1,421,758 101.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						
116.00	11600 HOSPICE	455,484		455,484		455,484 116.00	
200.00	Subtotal (see instructions)	40,143,766	0	40,143,766	0	40,143,766 200.00	
201.00	Less Observation Beds	744,694		744,694		744,694 201.00	
202.00	Total (see instructions)	39,399,072	0	39,399,072	0	39,399,072 202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150045

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

Worksheet C  
Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,780,980		7,780,980		30.00
31.00	03100	INTENSIVE CARE UNIT	3,961,022		3,961,022		31.00
43.00	04300	NURSERY	930,585		930,585		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,582,457	12,085,667	14,668,124	0.335262	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,847,070	27,633	1,874,703	0.659999	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,532,612	16,927,880	18,460,492	0.246785	54.00
60.00	06000	LABORATORY	2,621,949	16,971,543	19,593,492	0.262916	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	1,076,506	372,535	1,449,041	0.506554	65.00
66.00	06600	PHYSICAL THERAPY	362,667	2,486,800	2,849,467	0.597349	66.00
66.01	06601	CARDIAC REHAB	5,742	323,006	328,748	1.231287	66.01
69.00	06900	ELECTROCARDIOLOGY	122,797	715,596	838,393	0.180450	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,442	1,253,390	1,263,832	0.249724	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,704,662	3,782,557	5,487,219	0.302504	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,096,836	962,668	2,059,504	0.347685	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,942,430	4,120,434	6,062,864	0.508295	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	155	101,380	101,535	0.637002	90.00
91.00	09100	EMERGENCY	1,467,444	7,745,488	9,212,932	0.321056	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	1,486,713	1,486,713	0.500900	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	4,570,218	4,570,218	0.428750	95.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	1,279,572	1,279,572		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	31,870	729,018	760,888		116.00
200.00		Subtotal (see instructions)	29,078,226	75,942,098	105,020,324		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	29,078,226	75,942,098	105,020,324		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150045

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

Worksheet C  
Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000				30.00
31.00	03100				31.00
43.00	04300				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	0.335262			50.00
52.00	05200	0.659999			52.00
54.00	05400	0.246785			54.00
60.00	06000	0.262916			60.00
60.01	06001	0.000000			60.01
65.00	06500	0.506554			65.00
66.00	06600	0.597349			66.00
66.01	06601	1.231287			66.01
69.00	06900	0.180450			69.00
70.00	07000	0.249724			70.00
71.00	07100	0.302504			71.00
72.00	07200	0.347685			72.00
73.00	07300	0.508295			73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	0.637002			90.00
91.00	09100	0.321056			91.00
92.00	09200	0.500900			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	0.428750			95.00
99.10	09910				99.10
101.00	10100				101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
116.00	11600				116.00
200.00					200.00
201.00					201.00
202.00					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150045

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

Worksheet C  
Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	5,082,712		5,082,712	0	5,082,712 30.00
31.00	03100 INTENSIVE CARE UNIT	2,261,023		2,261,023	0	2,261,023 31.00
43.00	04300 NURSERY	568,387		568,387	0	568,387 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	4,917,670		4,917,670	0	4,917,670 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,237,302		1,237,302	0	1,237,302 52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,555,768		4,555,768	0	4,555,768 54.00
60.00	06000 LABORATORY	5,151,433		5,151,433	0	5,151,433 60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0 60.01
65.00	06500 RESPIRATORY THERAPY	734,017	0	734,017	0	734,017 65.00
66.00	06600 PHYSICAL THERAPY	1,702,125	0	1,702,125	0	1,702,125 66.00
66.01	06601 CARDIAC REHAB	404,783	0	404,783	0	404,783 66.01
69.00	06900 ELECTROCARDIOLOGY	151,288		151,288	0	151,288 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	315,609		315,609	0	315,609 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1,659,906		1,659,906	0	1,659,906 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	716,058		716,058	0	716,058 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,081,726		3,081,726	0	3,081,726 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	64,678		64,678	0	64,678 90.00
91.00	09100 EMERGENCY	2,957,866		2,957,866	0	2,957,866 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	744,694		744,694	0	744,694 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	1,959,479		1,959,479	0	1,959,479 95.00
99.10	09910 CORF	0		0	0	0 99.10
101.00	10100 HOME HEALTH AGENCY	1,421,758		1,421,758	0	1,421,758 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					
116.00	11600 HOSPICE	455,484		455,484		455,484 116.00
200.00	Subtotal (see instructions)	40,143,766	0	40,143,766	0	40,143,766 200.00
201.00	Less Observation Beds	744,694		744,694		744,694 201.00
202.00	Total (see instructions)	39,399,072	0	39,399,072	0	39,399,072 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150045

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

Worksheet C  
Part I  
Date/Time Prepared:  
2/25/2014 4:27 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			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	7,780,980		7,780,980		30.00
31.00	03100	INTENSIVE CARE UNIT	3,961,022		3,961,022		31.00
43.00	04300	NURSERY	930,585		930,585		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	2,582,457	12,085,667	14,668,124	0.335262	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,847,070	27,633	1,874,703	0.659999	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,532,612	16,927,880	18,460,492	0.246785	54.00
60.00	06000	LABORATORY	2,621,949	16,971,543	19,593,492	0.262916	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	1,076,506	372,535	1,449,041	0.506554	65.00
66.00	06600	PHYSICAL THERAPY	362,667	2,486,800	2,849,467	0.597349	66.00
66.01	06601	CARDIAC REHAB	5,742	323,006	328,748	1.231287	66.01
69.00	06900	ELECTROCARDIOLOGY	122,797	715,596	838,393	0.180450	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,442	1,253,390	1,263,832	0.249724	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,704,662	3,782,557	5,487,219	0.302504	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,096,836	962,668	2,059,504	0.347685	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,942,430	4,120,434	6,062,864	0.508295	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	155	101,380	101,535	0.637002	90.00
91.00	09100	EMERGENCY	1,467,444	7,745,488	9,212,932	0.321056	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	1,486,713	1,486,713	0.500900	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	4,570,218	4,570,218	0.428750	95.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	1,279,572	1,279,572		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	31,870	729,018	760,888		116.00
200.00		Subtotal (see instructions)	29,078,226	75,942,098	105,020,324		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	29,078,226	75,942,098	105,020,324		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150045

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

Worksheet C  
Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
66.01	06601 CARDIAC REHAB	0.000000			66.01
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	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
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
99.10	09910 CORF				99.10
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
116.00	11600 HOSPICE				116.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part I Date/Time Prepared: 2/25/2014 4:27 pm
		Title XVIII	Hospital	PPS

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	ADULTS & PEDIATRICS	583,530	0	583,530	4,648	125.54	30.00
31.00	INTENSIVE CARE UNIT	240,720		240,720	1,429	168.45	31.00
43.00	NURSERY	71,149		71,149	937	75.93	43.00
200.00	Total (Lines 30-199)	895,399		895,399	7,014		200.00

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	ADULTS & PEDIATRICS	1,224	153,661	30.00
31.00	INTENSIVE CARE UNIT	543	91,468	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (Lines 30-199)	1,767	245,129	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part II Date/Time Prepared: 2/25/2014 4:27 pm
--	----------------------	---	--

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	777,426	14,668,124	0.053001	489,978	25,969	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	208,019	1,874,703	0.110961	8,483	941	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	429,733	18,460,492	0.023279	873,152	20,326	54.00
60.00	06000	LABORATORY	261,550	19,593,492	0.013349	1,219,779	16,283	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	50,517	1,449,041	0.034862	485,808	16,936	65.00
66.00	06600	PHYSICAL THERAPY	221,952	2,849,467	0.077892	102,685	7,998	66.00
66.01	06601	CARDIAC REHAB	112,140	328,748	0.341112	1,672	570	66.01
69.00	06900	ELECTROCARDIOLOGY	2,478	838,393	0.002956	78,667	233	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,426	1,263,832	0.002711	7,061	19	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	62,120	5,487,219	0.011321	492,421	5,575	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,204	2,059,504	0.002041	345,214	705	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,672	6,062,864	0.010832	778,559	8,433	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	1,151	101,535	0.011336	0	0	90.00
91.00	09100	EMERGENCY	344,618	9,212,932	0.037406	578,084	21,624	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	85,496	1,486,713	0.057507	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,630,502	85,737,059		5,461,563	125,612	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150045		Period: From 10/01/2012 To 09/30/2013		Worksheet D Part III Date/Time Prepared: 2/25/2014 4:27 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00	
43.00	04300	NURSERY	0	0	0	0	0 43.00	
200.00		Total (lines 30-199)	0	0	0	0	0 200.00	
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)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,648	0.00	1,224	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	1,429	0.00	543	0	31.00	
43.00	04300	NURSERY	937	0.00	0	0	43.00	
200.00		Total (lines 30-199)	7,014		1,767	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150045

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

Worksheet D  
Part IV  
Date/Time Prepared:  
2/25/2014 4:27 pm

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	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150045

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

Worksheet D  
Part IV  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	14,668,124	0.000000	0.000000	489,978	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,874,703	0.000000	0.000000	8,483	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	18,460,492	0.000000	0.000000	873,152	54.00
60.00	06000 LABORATORY	0	19,593,492	0.000000	0.000000	1,219,779	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	1,449,041	0.000000	0.000000	485,808	65.00
66.00	06600 PHYSICAL THERAPY	0	2,849,467	0.000000	0.000000	102,685	66.00
66.01	06601 CARDIAC REHAB	0	328,748	0.000000	0.000000	1,672	66.01
69.00	06900 ELECTROCARDIOLOGY	0	838,393	0.000000	0.000000	78,667	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1,263,832	0.000000	0.000000	7,061	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	5,487,219	0.000000	0.000000	492,421	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2,059,504	0.000000	0.000000	345,214	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6,062,864	0.000000	0.000000	778,559	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	101,535	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	9,212,932	0.000000	0.000000	578,084	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0	1,486,713	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	85,737,059			5,461,563	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/25/2014 4:27 pm
--	----------------------	---	--

Cost Center Description	Title XVIII					Hospital		PPS
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1			
	11.00	12.00	12.01	13.00	13.01			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00 05000 OPERATING ROOM	0	523,508	1,571,748	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	804,796	2,384,427	0	0	0	0	54.00
60.00 06000 LABORATORY	0	186,015	374,220	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	19,856	55,778	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	588	1,587	0	0	0	0	66.00
66.01 06601 CARDIAC REHAB	0	28,241	81,554	0	0	0	0	66.01
69.00 06900 ELECTROCARDIOLOGY	0	37,879	119,275	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	104,204	196,032	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	105,951	311,286	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	24,973	104,275	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	303,033	876,569	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00 09000 CLINIC	0	9,090	26,446	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	310,025	973,980	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT)	0	95,736	259,279	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00 09500 AMBULANCE SERVICES								95.00
200.00 Total (lines 50-199)	0	2,553,895	7,336,456	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150045

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

Worksheet D  
Part V  
Date/Time Prepared:  
2/25/2014 4:27 pm

		Title XVIII		Hospital		PPS	
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
			PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
		1.00	2.00	2.01	3.00	4.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.335262	523,508	1,571,748	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.659999	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.246785	804,796	2,384,427	0	0	54.00
60.00	06000 LABORATORY	0.262916	186,015	374,220	1,165	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.506554	19,856	55,778	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.597349	588	1,587	0	0	66.00
66.01	06601 CARDIAC REHAB	1.231287	28,241	81,554	0	0	66.01
69.00	06900 ELECTROCARDIOLOGY	0.180450	37,879	119,275	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.249724	104,204	196,032	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.302504	105,951	311,286	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.347685	24,973	104,275	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.508295	303,033	876,569	0	11,429	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.637002	9,090	26,446	0	0	90.00
91.00	09100 EMERGENCY	0.321056	310,025	973,980	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.500900	95,736	259,279	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0.428750			0		95.00
200.00	Subtotal (see instructions)		2,553,895	7,336,456	1,165	11,429	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		2,553,895	7,336,456	1,165	11,429	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/25/2014 4:27 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs					
	PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	5.00	5.01	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	175,512	526,947	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	198,612	588,441	0	0	54.00
60.00	06000 LABORATORY	48,906	98,388	306	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	10,058	28,255	0	0	65.00
66.00	06600 PHYSICAL THERAPY	351	948	0	0	66.00
66.01	06601 CARDIAC REHAB	34,773	100,416	0	0	66.01
69.00	06900 ELECTROCARDIOLOGY	6,835	21,523	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	26,022	48,954	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	32,051	94,165	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	8,683	36,255	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	154,030	445,556	0	5,809	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	5,790	16,846	0	0	90.00
91.00	09100 EMERGENCY	99,535	312,702	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	47,954	129,873	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES			0		95.00
200.00	Subtotal (see instructions)	849,112	2,449,269	306	5,809	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0		201.00
202.00	Net Charges (line 200 +/- line 201)	849,112	2,449,269	306	5,809	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 2/25/2014 4:27 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,648	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,648	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)		3,967	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,224	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,082,712	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,082,712	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,082,712	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,093.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,338,481	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)		1,338,481	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150045		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1 Date/Time Prepared: 2/25/2014 4:27 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)	
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	
42.00	Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42.00
43.00	INTENSIVE CARE UNIT	2,261,023	1,429	1,582.24	543	859,156	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,881,814	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,079,451	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)					245,129	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					125,612	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					370,741	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,708,710	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)					681	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,093.53	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					744,694	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150045		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1 Date/Time Prepared: 2/25/2014 4:27 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	583,530	5,082,712	0.114807	744,694	85,496	90.00
91.00	Nursing School cost	0	5,082,712	0.000000	744,694	0	91.00
92.00	Allied health cost	0	5,082,712	0.000000	744,694	0	92.00
93.00	All other Medical Education	0	5,082,712	0.000000	744,694	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 2/25/2014 4:27 pm
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,648	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,648	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)		3,967	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)		414	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)		937	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,082,712	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,082,712	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,082,712	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,093.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		452,721	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)		452,721	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1 Date/Time Prepared: 2/25/2014 4:27 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)	568,387	937	606.60	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,261,023	1,429	1,582.24	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)				586,183	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				1,038,904	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)				681	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,093.53	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				744,694	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150045

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

Worksheet D-1

Date/Time Prepared:  
2/25/2014 4:27 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/25/2014 4:27 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		2,356,390	30.00
31.00	03100	INTENSIVE CARE UNIT		1,639,961	31.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.335262	489,978	164,271 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.659999	8,483	5,599 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246785	873,152	215,481 54.00
60.00	06000	LABORATORY	0.262916	1,219,779	320,699 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0.506554	485,808	246,088 65.00
66.00	06600	PHYSICAL THERAPY	0.597349	102,685	61,339 66.00
66.01	06601	CARDIAC REHAB	1.231287	1,672	2,059 66.01
69.00	06900	ELECTROCARDIOLOGY	0.180450	78,667	14,195 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.249724	7,061	1,763 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.302504	492,421	148,959 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.347685	345,214	120,026 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.508295	778,559	395,738 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.637002	0	0 90.00
91.00	09100	EMERGENCY	0.321056	578,084	185,597 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0.500900	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			
200.00		Total (sum of lines 50-94 and 96-98)		5,461,563	1,881,814 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		5,461,563	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/25/2014 4:27 pm	
Cost Center Description		Title XIX	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		552,393	30.00
31.00	03100	INTENSIVE CARE UNIT		193,418	31.00
43.00	04300	NURSERY		245,585	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.335262	229,120	76,815 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.659999	463,810	306,114 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246785	35,277	8,706 54.00
60.00	06000	LABORATORY	0.262916	168,348	44,261 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0.506554	78,750	39,891 65.00
66.00	06600	PHYSICAL THERAPY	0.597349	36,897	22,040 66.00
66.01	06601	CARDIAC REHAB	1.231287	714	879 66.01
69.00	06900	ELECTROCARDIOLOGY	0.180450	2,564	463 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.249724	635	159 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.302504	41,759	12,632 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.347685	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.508295	113,636	57,761 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.637002	49	31 90.00
91.00	09100	EMERGENCY	0.321056	51,179	16,431 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.500900	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			
200.00		Total (sum of lines 50-94 and 96-98)		1,222,738	586,183 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		1,222,738	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part A Date/Time Prepared: 2/25/2014 4:27 pm	
		Title XVIII	Hospital	PPS	
		0	before 1/1	on/after 1/1	
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>					
1.00	DRG Amounts Other than Outlier Payments		2,700,254		1.00
2.00	Outlier payments for discharges. (see instructions)		9,211		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)		45.13		4.00
<b>Indirect Medical Education Adjustment</b>					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(F)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(F)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (F)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment. (see instructions)		0.000000		27.00
28.00	IME Adjustment (see instructions)		0		28.00
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
<b>Disproportionate Share Adjustment</b>					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.33		30.00
31.00	Percentage of Medicaid patient days (see instructions)		25.58		31.00
32.00	Sum of lines 30 and 31		30.91		32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00		33.00
34.00	Disproportionate share adjustment (see instructions)		324,030		34.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part A Date/Time Prepared: 2/25/2014 4:27 pm	
		Title XVIII	Hospital	PPS	
		0	before 1/1	on/after 1/1	
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	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)		3,033,495		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		3,033,495		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		212,556		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).		0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		3,246,051		59.00
60.00	Primary payer payments		13,501		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		3,232,550		61.00
62.00	Deductibles billed to program beneficiaries		453,040		62.00
63.00	Coinurance billed to program beneficiaries		29,502		63.00
64.00	Allowable bad debts (see instructions)		60,340		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		39,221		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		34,981		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		2,789,229		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		5,676		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		0		70.94
70.95	Recovery of Accelerated Depreciation		0		70.95
70.96	Low Volume Payment-1 (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low Volume Payment-2 (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2013	488,648		70.97
70.98	Low Volume Payment-3		0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,283,553		71.00
71.01	Sequestration adjustment (see instructions)		32,836		71.01
72.00	Interim payments		3,180,349		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		70,368		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0		75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part A Date/Time Prepared: 2/25/2014 4:27 pm	
		Title XVIII	Hospital	PPS	
			before 1/1	on/after 1/1	
		0	1.00	1.01	
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150045

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
2/25/2014 4:27 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01		
		0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00	2,700,254	0	0	2,700,254	1.00	
2.00	Outlier payments for discharges (see instructions)	2.00	9,211	0	0	9,211	2.00	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00	
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	5.00	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00	
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00	
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200	10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	324,030	0	0	324,030	11.00	
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	3,033,495	0	0	3,033,495	13.00	
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	48.00	0	0	0	0	14.00	
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	3,033,495	0	0	3,033,495	15.00	
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	212,556	0	0	212,556	16.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00	
19.00	<b>SUBTOTAL</b>			0	0	3,246,051	19.00	
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	211,425	0	0	211,425	20.00	
21.00	Capital DRG outlier payments	2.00	1,131	0	0	1,131	21.00	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	22.00	
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	24.00	
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	0	0	0	0	25.00	
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	212,556	0	0	212,556	26.00	
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00		
27.00	Low volume adjustment factor				0.000000	0.150536	27.00	
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			0		28.00	
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				488,648	29.00	
100.00	Transfer low volume adjustments to W/S E Part A.		Y				100.00	

LOW VOLUME CALCULATION EXHIBIT 4		Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/25/2014 4:27 pm
		Title XVII	Hospital	PPS
		Total (Col 2 through 4) 5.00		
1.00	DRG amounts other than outlier payments	2,700,254		1.00
2.00	Outlier payments for discharges (see instructions)	9,211		2.00
3.00	Operating outlier reconciliation	0		3.00
4.00	Managed care simulated payments	0		4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)			5.00
6.00	IME payment adjustment (see instructions)	0		6.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
7.00	Amount from Worksheet E Part A, line 27 (see instructions)			7.00
8.00	IME adjustment (see instructions)	0		8.00
9.00	Total IME payment (sum of lines 6 and 8)	0		9.00
<b>Disproportionate Share Adjustment</b>				
10.00	Allowable disproportionate share percentage (see instructions)			10.00
11.00	Disproportionate share adjustment (see instructions)	324,030		11.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>				
12.00	Total ESRD additional payment (see instructions)	0		12.00
13.00	Subtotal (see instructions)	3,033,495		13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	3,033,495		15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	212,556		16.00
17.00	Special add-on payments for new technologies	0		17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	0		18.00
19.00	<b>SUBTOTAL</b>	<b>3,246,051</b>		<b>19.00</b>
		5.00		
20.00	Capital DRG other than outlier	211,425		20.00
21.00	Capital DRG outlier payments	1,131		21.00
22.00	Indirect medical education percentage (see instructions)			22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	0		23.00
24.00	Allowable disproportionate share percentage (see instructions)			24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	0		25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	212,556		26.00
		5.00		
27.00	Low volume adjustment factor			27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	0		28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	488,648		29.00
100.00	Transfer low volume adjustments to W/S E Part A.			100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part B Date/Time Prepared: 2/25/2014 4:27 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		6,115	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		849,112	2,449,269
3.00	PPS payments		595,302	1,732,266
4.00	Outlier payment (see instructions)		316	6,406
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.851	0.851
6.00	Line 2 times line 5		722,594	2,084,328
7.00	Sum of line 3 plus line 4 divided by line 6		82.43	83.42
8.00	Transitional corridor payment (see instructions)		107,930	0
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	0
10.00	Organ acquisitions		0	0
11.00	Total cost (sum of lines 1 and 10) (see instructions)		6,115	0
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		12,594	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)		12,594	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)		12,594	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		6,479	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		6,115	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		2,442,220	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)		586,631	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)		1,861,704	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)		1,861,704	30.00
31.00	Primary payer payments		833	31.00
32.00	Subtotal (line 30 minus line 31)		1,860,871	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		119,211	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		77,487	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		88,444	36.00
37.00	Subtotal (see instructions)		1,938,358	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-31	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,938,389	40.00
40.01	Sequestration adjustment (see instructions)		19,384	40.01
41.00	Interim payments		1,910,328	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		8,677	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150045

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/25/2014 4:27 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		3,180,349		1,732,040	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	10/01/2012	26,432	3.01	
3.02			0	11/01/2012	44,172	3.02	
3.03			0	12/03/2012	60,516	3.03	
3.04			0	01/02/2013	47,168	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		178,288	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,180,349		1,910,328	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		70,368		8,677	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		3,250,717		1,919,005	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 150045

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

Worksheet E-1  
Part II  
Date/Time Prepared:  
2/25/2014 4:27 pm

		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			2,011 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,767 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			1,093 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			5,396 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			105,020,324 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			1,155,000 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			873,142 8.00
9.00	Sequestration adjustment amount (see instructions)			17,463 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			855,679 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			829,095 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			26,584 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part VII Date/Time Prepared: 2/25/2014 4:27 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		1,038,904		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)		1,038,904	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)		1,038,904	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		991,445		8.00
9.00	Ancillary service charges		1,222,738	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)		2,214,183	0	12.00
<b>CUSTOMARY CHARGES</b>					
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)		2,214,183	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,175,279	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)		1,038,904	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
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)		1,038,904	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
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)		1,038,904	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		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)		1,038,904	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		1,038,904	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)		1,038,904	0	40.00
41.00	Interim payments		1,425,091	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		-386,187		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		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: 150045

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

Worksheet G

Date/Time Prepared:  
2/25/2014 4:27 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	58,810	0	0	0	1.00
2.00	Temporary investments	1,817	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	15,345,117	0	0	0	4.00
5.00	Other receivable	1,486,027	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,122,440	0	0	0	6.00
7.00	Inventory	995,723	0	0	0	7.00
8.00	Prepaid expenses	1,050,045	0	0	0	8.00
9.00	Other current assets	961,938	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)	12,777,037	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	393,118	0	0	0	12.00
13.00	Land improvements	1,699,339	0	0	0	13.00
14.00	Accumulated depreciation	-1,293,545	0	0	0	14.00
15.00	Buildings	52,726,621	0	0	0	15.00
16.00	Accumulated depreciation	-23,311,152	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	-631,534	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	-163,422	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	20,947,607	0	0	0	23.00
24.00	Accumulated depreciation	-12,824,725	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	-37,049	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)	37,505,258	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	17,207,351	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	17,207,351	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	67,489,646	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	1,779,428	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,051,535	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,823,028	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,789,779	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,443,770	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	5,906,604	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,906,604	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,350,374	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	51,139,272	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	51,139,272	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	67,489,646	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150045

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

Worksheet G-1

Date/Time Prepared:  
2/25/2014 4:27 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		50,432,915		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		706,357				2.00
3.00	Total (sum of line 1 and line 2)		51,139,272		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		51,139,272		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		51,139,272		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150045

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	8,748,850		8,748,850	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,748,850		8,748,850	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,992,499		3,992,499	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)	3,992,499		3,992,499	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	12,741,349		12,741,349	17.00
18.00	Ancillary services	14,842,297	59,969,620	74,811,917	18.00
19.00	Outpatient services	1,467,696	9,381,558	10,849,254	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,291,684	1,291,684	22.00
23.00	AMBULANCE SERVICES	0	4,570,218	4,570,218	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	31,875	729,018	760,893	26.00
27.00	DIETARY	66	20,679	20,745	27.00
27.01	DHMG PHYSICIAN OFFICES	0	7,837,870	7,837,870	27.01
27.02	SELF-INSURANCE	410,243	1,241,395	1,651,638	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	29,493,526	85,042,042	114,535,568	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		55,474,348		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)		55,474,348		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150045

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

Worksheet G-3

Date/Time Prepared:  
2/25/2014 4:27 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	114,535,568	1.00
2.00	Less contractual allowances and discounts on patients' accounts	63,403,265	2.00
3.00	Net patient revenues (line 1 minus line 2)	51,132,303	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	55,474,348	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,342,045	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	2,288,538	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	2,759,864	24.00
25.00	Total other income (sum of lines 6-24)	5,048,402	25.00
26.00	Total (line 5 plus line 25)	706,357	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	706,357	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150045

Period: From 10/01/2012

Worksheet H

HHA CCN: 157157

To 09/30/2013

Date/Time Prepared: 2/25/2014 4:27 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	301,063	0	0	0	220,039	521,102	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	214,763	0	0	0	0	214,763	6.00
7.00	110,803	0	0	0	0	110,803	7.00
8.00	0	0	0	0	0	0	8.00
9.00	0	0	0	0	0	0	9.00
10.00	8,189	0	0	0	0	8,189	10.00
11.00	82,536	0	0	0	0	82,536	11.00
12.00	0	0	0	0	0	0	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
24.00	717,354	0	0	0	220,039	937,393	24.00
	Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	9,270	530,372	-71,114	459,258			5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	0	214,763	0	214,763			6.00
7.00	0	110,803	0	110,803			7.00
8.00	0	0	0	0			8.00
9.00	0	0	0	0			9.00
10.00	0	8,189	0	8,189			10.00
11.00	0	82,536	0	82,536			11.00
12.00	0	0	0	0			12.00
13.00	0	0	0	0			13.00
14.00	0	0	0	0			14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	0	0	0			23.00
24.00	9,270	946,663	-71,114	875,549			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet H-1 Part I Date/Time Prepared: 2/25/2014 4:27 pm
		HHA CCN: 157157	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bl dgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0	0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	459,258	0	0	0	459,258	5.00	
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	214,763	0	0	0	214,763	6.00	
7.00	Physical Therapy	110,803	0	0	0	110,803	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	8,189	0	0	0	8,189	10.00	
11.00	Home Health Aide	82,536	0	0	0	82,536	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	
<b>HHA NONREIMBURSABLE SERVICES</b>								
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)	875,549	0	0	0	875,549	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures						1.00	
2.00	Capital Related - Movable Equipment						2.00	
3.00	Plant Operation & Maintenance						3.00	
4.00	Transportation						4.00	
5.00	Administrative and General	459,258					5.00	
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	236,930	451,693				6.00	
7.00	Physical Therapy	122,239	233,042				7.00	
8.00	Occupational Therapy	0	0				8.00	
9.00	Speech Pathology	0	0				9.00	
10.00	Medical Social Services	9,034	17,223				10.00	
11.00	Home Health Aide	91,055	173,591				11.00	
12.00	Supplies (see instructions)	0	0				12.00	
13.00	Drugs	0	0				13.00	
14.00	DME	0	0				14.00	
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	0	0				23.00	
24.00	Total (sum of lines 1-23)		875,549				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 150045  
HHA CCN: 157157

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

Worksheet H-1  
Part II  
Date/Time Prepared:  
2/25/2014 4:27 pm

Home Health  
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-459,258	416,291
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	0	0	0	0	214,763
7.00	Physical Therapy	0	0	0	0	0	110,803
8.00	Occupational Therapy	0	0	0	0	0	0
9.00	Speech Pathology	0	0	0	0	0	0
10.00	Medical Social Services	0	0	0	0	0	8,189
11.00	Home Health Aide	0	0	0	0	0	82,536
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-459,258	416,291
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		459,258
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		1.103214

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150045  
HHA CCN: 157157

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

Worksheet H-2  
Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm  
PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS					BUTLER - NEW	
		BLDG & FIXT	MAC WEST - NEW	NORTH ANNEX - NEW	GARRETT CLINIC - NEW			
		1.00	1.01	1.02	1.03	1.04		
1.00 Administrative and General	0	0	0	2,333	0	0	1.00	
2.00 Skilled Nursing Care	451,693	0	0	0	0	0	2.00	
3.00 Physical Therapy	233,042	0	0	0	0	0	3.00	
4.00 Occupational Therapy	0	0	0	0	0	0	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	17,223	0	0	0	0	0	6.00	
7.00 Home Health Aide	173,591	0	0	0	0	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19) (2)	875,549	0	0	2,333	0	0	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00	
CAPITAL RELATED COSTS								
Cost Center Description	MAC EAST - NEW	GARRETT LAB - NEW	MEDICAL ARTS - NEW	DAY SPRING - NEW	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT		
	1.05	1.06	1.07	1.08	2.00	4.00		
1.00 Administrative and General	0	0	0	0	0	95,106	1.00	
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00 Physical Therapy	0	0	0	0	0	0	3.00	
4.00 Occupational Therapy	0	0	0	0	0	0	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	0	0	0	0	0	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19) (2)	0	0	0	0	0	95,106	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00	

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150045

Period: From 10/01/2012

Worksheet H-2

HHA CCN: 157157

To 09/30/2013

Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Home Health  
Agency I

PPS

Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4A	5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	97,439	19,116	86,178	0	24,010	0	1.00
2.00	Skilled Nursing Care	451,693	88,614	0	0	0	0	2.00
3.00	Physical Therapy	233,042	45,719	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	17,223	3,379	0	0	0	0	6.00
7.00	Home Health Aide	173,591	34,055	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	972,988	190,883	86,178	0	24,010	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.000000						21.00

  

Cost Center Description		SNACK BAR	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10.01	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	36,588	111,111	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	36,588	111,111	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150045

Period: From 10/01/2012

Worksheet H-2

HHA CCN: 157157

To 09/30/2013

Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Home Health Agency I

PPS

Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
	17.00	24.00	25.00	26.00	27.00	28.00	
1.00 Administrative and General	0	374,442	0	374,442			1.00
2.00 Skilled Nursing Care	0	540,307	0	540,307	193,173	733,480	2.00
3.00 Physical Therapy	0	278,761	0	278,761	99,664	378,425	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	20,602	0	20,602	7,366	27,968	6.00
7.00 Home Health Aide	0	207,646	0	207,646	74,239	281,885	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	0	1,421,758	0	1,421,758	374,442	1,421,758	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.					0.357525		21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150045  
HHA CCN: 157157

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

Worksheet H-2  
Part II  
Date/Time Prepared:  
2/25/2014 4:27 pm

Home Health Agency I

PPS

Cost Center Description	CAPITAL RELATED COSTS							
	BLDG & FIXT (SQUARE FEET)	MAC WEST - NEW (SQUARE FEET)	NORTH ANNEX - NEW (SQUARE FEET)	GARRETT CLINIC - NEW (SQUARE FEET)	BUTLER - NEW (SQUARE FEET)	MAC EAST - NEW (SQUARE FEET)		
	1.00	1.01	1.02	1.03	1.04	1.05		
1.00 Administrative and General	0	0	2,772	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	2,772	0	0	0	0	20.00
21.00 Total cost to be allocated	0	0	2,333	0	0	0	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.841631	0.000000	0.000000	0.000000	0.000000	22.00

  

Cost Center Description	CAPITAL RELATED COSTS					EMPLOYEE BENEFITS DEPARTMENT (UNADJUSTED SALARY)	Reconciliation	
	GARRETT LAB - NEW (SQUARE FEET)	MEDICAL ARTS - NEW (SQUARE FEET)	DAY SPRING - NEW (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.06	1.07	1.08	2.00	4.00			
1.00 Administrative and General	0	0	0	0	718,451	5A	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0		0	2.00
3.00 Physical Therapy	0	0	0	0	0		0	3.00
4.00 Occupational Therapy	0	0	0	0	0		0	4.00
5.00 Speech Pathology	0	0	0	0	0		0	5.00
6.00 Medical Social Services	0	0	0	0	0		0	6.00
7.00 Home Health Aide	0	0	0	0	0		0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0		0	8.00
9.00 Drugs	0	0	0	0	0		0	9.00
10.00 DME	0	0	0	0	0		0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0		0	11.00
12.00 Respiratory Therapy	0	0	0	0	0		0	12.00
13.00 Private Duty Nursing	0	0	0	0	0		0	13.00
14.00 Clinic	0	0	0	0	0		0	14.00
15.00 Health Promotion Activities	0	0	0	0	0		0	15.00
16.00 Day Care Program	0	0	0	0	0		0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0		0	17.00
18.00 Homemaker Service	0	0	0	0	0		0	18.00
19.00 All Others (specify)	0	0	0	0	0		0	19.00
20.00 Total (sum of lines 1-19)	0	0	0	0	718,451		0	20.00
21.00 Total cost to be allocated	0	0	0	0	95,106		0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.132376		0	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150045  
HHA CCN: 157157

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

Worksheet H-2  
Part II  
Date/Time Prepared:  
2/25/2014 4:27 pm

Home Health Agency I PPS

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	SNACK BAR (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	10.01	
1.00	Administrative and General	97,439	2,772	0	2,772	0	0	1.00
2.00	Skilled Nursing Care	451,693	0	0	0	0	0	2.00
3.00	Physical Therapy	233,042	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	17,223	0	0	0	0	0	6.00
7.00	Home Health Aide	173,591	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	972,988	2,772	0	2,772	0	0	20.00
21.00	Total cost to be allocated	190,883	86,178	0	24,010	0	0	21.00
22.00	Unit cost multiplier	0.196182	31.088745	0.000000	8.661616	0.000000	0.000000	22.00
Cost Center Description		CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	1,323	27,527	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,323	27,527	0	0	0	0	20.00
21.00	Total cost to be allocated	36,588	111,111	0	0	0	0	21.00
22.00	Unit cost multiplier	27.655329	4.036437	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 150045 HHA CCN: 157157	Period: From 10/01/2012 To 09/30/2013	Worksheet H-3 Part I Date/Time Prepared: 2/25/2014 4:27 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	Average Cost Per Visit (col. 3 ÷ col. 4)		
	0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	733,480		733,480	4,595	159.63	1.00
2.00	Physical Therapy	3.00	378,425	0	378,425	1,741	217.36	2.00
3.00	Occupational Therapy	4.00	0	0	0	0	0.00	3.00
4.00	Speech Pathology	5.00	0	0	0	0	0.00	4.00
5.00	Medical Social Services	6.00	27,968		27,968	40	699.20	5.00
6.00	Home Health Aide	7.00	281,885		281,885	2,648	106.45	6.00
7.00	Total (sum of lines 1-6)		1,421,758	0	1,421,758	9,024		7.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles								
Cost Center Description	Cost Limits	CBSA No. (1)	Part A	3.00	4.00	5.00		
	0	1.00	2.00					
Limitation Cost Computation								
8.00	Skilled Nursing Care		99915	922	713			8.00
9.00	Physical Therapy		99915	286	212			9.00
10.00	Occupational Therapy		99915	0	0			10.00
11.00	Speech Pathology		99915	0	0			11.00
12.00	Medical Social Services		99915	11	10			12.00
13.00	Home Health Aide		99915	277	276			13.00
14.00	Total (sum of lines 8-13)			1,496	1,211			14.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)		
	0	1.00	2.00	3.00	4.00	5.00		
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
Cost Center Description	Part A	7.00	8.00	9.00	10.00	11.00		
	6.00							
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	922	713		147,179	113,816		1.00
2.00	Physical Therapy	286	212		62,165	46,080		2.00
3.00	Occupational Therapy	0	0		0	0		3.00
4.00	Speech Pathology	0	0		0	0		4.00
5.00	Medical Social Services	11	10		7,691	6,992		5.00
6.00	Home Health Aide	277	276		29,487	29,380		6.00
7.00	Total (sum of lines 1-6)	1,496	1,211		246,522	196,268		7.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS			Provider CCN: 150045 HHA CCN: 157157		Period: From 10/01/2012 To 09/30/2013		Worksheet H-3 Part I Date/Time Prepared: 2/25/2014 4:27 pm	
			Title XVII I		Home Health Agency I		PPS	
Cost Center Description	Program Covered Charges			Cost of Services				
	Part A	Part B			Part A	Part B		
		Not Subject to Deductibles & Co Insurance	Subject to Deductibles & Co Insurance			Not Subject to Deductibles & Co Insurance	Subject to Deductibles & Co Insurance	
	6.00	7.00	8.00	9.00	10.00	11.00		
<b>Supplies and Drugs Cost Computations</b>								
15.00	Cost of Medical Supplies		0	0		0		15.00
16.00	Cost of Drugs						0	16.00
Cost Center Description		Total Program Cost (sum of col s. 9-10)						
		12.00						
<b>PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION</b>								
<b>Cost Per Visit Computation</b>								
1.00	Skilled Nursing Care	260,995						1.00
2.00	Physical Therapy	108,245						2.00
3.00	Occupational Therapy	0						3.00
4.00	Speech Pathology	0						4.00
5.00	Medical Social Services	14,683						5.00
6.00	Home Health Aide	58,867						6.00
7.00	Total (sum of lines 1-6)	442,790						7.00
Cost Center Description								
		12.00						
<b>Limitation Cost Computation</b>								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150045 HHA CCN: 157157	Period: From 10/01/2012 To 09/30/2013	Worksheet H-3 Part II Date/Time Prepared: 2/25/2014 4:27 pm
Title XVIII			Home Health Agency I	PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>						
1.00	Physical Therapy	66.00	0.597349	0	0	col. 2, line 2.00 1.00
1.01	Physical Therapy 1	66.01	1.231287	0	0	col. 2, line 2.01 1.01
2.00	Occupational Therapy					2.00
3.00	Speech Pathology					3.00
4.00	Cost of Medical Supplies	71.00	0.302504	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.508295	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 150045 HHA CCN: 157157	Period: From 10/01/2012 To 09/30/2013	Worksheet H-4 Part I-11 Date/Time Prepared: 2/25/2014 4:27 pm
		Title XVII I	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
<b>PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES</b>				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
<b>PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT</b>				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		190,565	159,820
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	2,748
13.00	Total PPS Reimbursement - LUPA Episodes		2,447	5,278
14.00	Total PPS Reimbursement - PEP Episodes		1,353	1,363
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	2,346
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)			0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		194,365	171,555
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		194,365	171,555
25.00	Coinsurance billed to program patients (from your records)			0
26.00	Net cost (line 24 minus line 25)		194,365	171,555
27.00	Reimbursable bad debts (from your records)			
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			
29.00	Total costs - current cost reporting period (line 26 plus line 27)		194,365	171,555
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		194,365	171,555
31.01	Sequestration adjustment (see instructions)		1,551	1,422
32.00	Interim payments (see instructions)		192,814	170,131
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33		0	2
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	0

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

Provider CCN: 150045  
HHA CCN: 157157

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

Worksheet H-5  
Date/Time Prepared:  
2/25/2014 4:27 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		192,814		170,131	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)		192,814		170,131	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		1,551		1,424	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		194,365		171,555	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150045

Period: From 10/01/2012

Worksheet K

Hospice CCN: 151559

To 09/30/2013

Date/Time Prepared: 2/25/2014 4:27 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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	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	25,402	0	11,534	52,403	73,524	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	10,447	0	0	0	0	9.00
10.00	Nursing Care	83,786	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	63	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	38,243	0	0	0	0	15.00
16.00	Spiritual Counseling	2,611	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	15,747	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	176,299	0	11,534	52,403	73,524	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150045

Period: From 10/01/2012

Worksheet K

Hospice CCN: 151559

To 09/30/2013

Date/Time Prepared: 2/25/2014 4:27 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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	162,863	1,154	164,017	-308	163,709	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	10,447	0	10,447	0	10,447	9.00
10.00	Nursing Care	83,786	0	83,786	0	83,786	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	63	0	63	0	63	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	38,243	0	38,243	0	38,243	15.00
16.00	Spiritual Counseling	2,611	0	2,611	0	2,611	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	15,747	0	15,747	0	15,747	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	313,760	1,154	314,914	-308	314,606	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150045

Period: From 10/01/2012

Worksheet K-1

Hospice CCN: 151559

To 09/30/2013

Date/Time Prepared: 2/25/2014 4:27 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	14,010	6,950	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	83,786	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	38,243	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	14,010	6,950	38,243	0	83,786	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150045

Period: From 10/01/2012

Worksheet K-1

Hospice CCN: 151559

To 09/30/2013

Date/Time Prepared: 2/25/2014 4:27 pm

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	4,442	25,402	6.00
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
<b>VISITING SERVICES</b>						
9.00	Physician Services		0	10,447	10,447	9.00
10.00	Nursing Care		0	0	83,786	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	63	0	0	63	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	38,243	15.00
16.00	Spiritual Counseling		0	2,611	2,611	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		15,747	0	15,747	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	63	15,747	17,500	176,299	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES	Provider CCN: 150045 Hospice CCN: 151559	Period: From 10/01/2012 To 09/30/2013	Worksheet K-3 Date/Time Prepared: 2/25/2014 4:27 pm
--	---	---	---

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

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES	Provider CCN: 150045 Hospice CCN: 151559	Period: From 10/01/2012 To 09/30/2013	Worksheet K-3 Date/Time Prepared: 2/25/2014 4:27 pm
--	---	---	---

		Total Therapists	Aides	All-Other	Hospice I Total (1)	
		6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	52,403	52,403	6.00
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
<b>VISITING SERVICES</b>						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	0	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	0	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	52,403	52,403	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150045  
 Hospice CCN: 151559

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

Worksheet K-4  
 Part I  
 Date/Time Prepared:  
 2/25/2014 4:27 pm

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	163,709	0	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	10,447	0	0	0	0	9.00
10.00	Nursing Care	83,786	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	63	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	38,243	0	0	0	0	15.00
16.00	Spiritual Counseling	2,611	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	15,747	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	314,606	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150045

Period: From 10/01/2012

Worksheet K-4

Hospice CCN: 151559

To 09/30/2013

Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)	
		5.00	5A	6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance					3.00
4.00	Transportation - Staff					4.00
5.00	Volunteer Service Coordination	0				5.00
6.00	Administrative and General	0	163,709	163,709		6.00
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
<b>VISITING SERVICES</b>						
9.00	Physician Services	0	10,447	11,334	21,781	9.00
10.00	Nursing Care	0	83,786	90,900	174,686	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	63	68	131	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	38,243	41,490	79,733	15.00
16.00	Spiritual Counseling	0	2,611	2,833	5,444	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	15,747	17,084	32,831	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
<b>OTHER HOSPICE SERVICE COSTS</b>						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	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
<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	314,606		314,606	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045  
 Hospice CCN: 151559

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

Worksheet K-4  
 Part II  
 Date/Time Prepared:  
 2/25/2014 4:27 pm

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045  
 Hospice CCN: 151559

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

Worksheet K-4  
 Part II  
 Date/Time Prepared:  
 2/25/2014 4:27 pm

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	Hospice I
		6A	6.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-163,709	150,897	6.00
<b>INPATIENT CARE SERVICE</b>				
7.00	Inpatient - General Care	0	0	7.00
8.00	Inpatient - Respite Care	0	0	8.00
<b>VISITING SERVICES</b>				
9.00	Physician Services	0	10,447	9.00
10.00	Nursing Care	0	83,786	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	63	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	38,243	15.00
16.00	Spiritual Counseling	0	2,611	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	15,747	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	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
<b>HOSPICE NONREIMBURSABLE SERVICE</b>				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		163,709	39.00
40.00	Unit Cost Multiplier		1.084906	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150045

Period: From 10/01/2012

Worksheet K-5

Hospice CCN: 151559

To 09/30/2013

Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		Hospice Trial Balance (1)	CAPITAL RELATED COSTS				
			BLDG & FIXT	MAC WEST - NEW	NORTH ANNEX - NEW	GARRETT CLINIC - NEW	
			1.00	1.01	1.02	1.03	
1.00	Administrative and General	0	0	0	252	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	21,781	0	0	0	0	4.00
5.00	Nursing Care	174,686	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	131	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	79,733	0	0	0	0	10.00
11.00	Spiritual Counseling	5,444	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	32,831	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)	314,606	0	0	252	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150045

Period:

Worksheet K-5

Hospice CCN: 151559

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

Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Hospice I

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150045

Period: From 10/01/2012

Worksheet K-5

Hospice CCN: 151559

To 09/30/2013

Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		MVBLE	EQUIP					
		2.00		4.00	4A	5.00	7.00	
1.00	Administrative and General	0	0	23,374	23,626	4,635	9,327	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	21,781	4,273	0	4.00
5.00	Nursing Care	0	0	0	174,686	34,270	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	131	26	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	79,733	15,642	0	10.00
11.00	Spiritual Counseling	0	0	0	5,444	1,068	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	32,831	6,441	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	23,374	338,232	66,355	9,327	34.00
35.00	Unit Cost Multiplier (see instructions)				0.000000			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150045

Period:

Worksheet K-5

Hospice CCN: 151559

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

Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		Hospice I					
		LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	SNACK BAR 10.01	CAFETERIA 11.00	
1.00	Administrative and General	77	2,598	0	0	7,550	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specif y	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	77	2,598	0	0	7,550	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150045

Period: From 10/01/2012

Worksheet K-5

Hospice CCN: 151559

To 09/30/2013

Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description	Hospice I					SOCIAL SERVICE	
	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY			
	13.00	14.00	15.00	16.00	17.00		
1.00 Administrative and General	22,951	0	0	8,394	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)	22,951	0	0	8,394	0	0	34.00
35.00 Unit Cost Multiplier (see instructions)							35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150045

Period: From 10/01/2012

Worksheet K-5

Hospice CCN: 151559

To 09/30/2013

Part I  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description	Hospice I					Total Hospice Costs (cols. 26 ± 27)	
	Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)			
	24.00	25.00	26.00	27.00	28.00		
1.00 Administrative and General	79,158						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	26,054	0	26,054	5,480	31,534	4,000	4.00
5.00 Nursing Care	208,956	0	208,956	43,952	252,908	5,000	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	0	6.00
7.00 Physical Therapy	157	0	157	33	190	7,000	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	95,375	0	95,375	20,062	115,437	10,000	10.00
11.00 Spiritual Counseling	6,512	0	6,512	1,370	7,882	11,000	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	39,272	0	39,272	8,261	47,533	14,000	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 - Specif y	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)	455,484	0	455,484		455,484		34.00
35.00 Unit Cost Multiplier (see instructions)				0.210344			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 150045

Period:

Worksheet K-5

Hospice CCN: 151559

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

Part II  
Date/Time Prepared:  
2/25/2014 4:27 pm

Hospice I

Cost Center Description	CAPITAL RELATED COSTS					
	BLDG & FIXT (SQUARE FEET)	MAC WEST - NEW (SQUARE FEET)	NORTH ANNEX - NEW (SQUARE FEET)	GARRETT CLINIC - NEW (SQUARE FEET)	BUTLER - NEW (SQUARE FEET)	
	1.00	1.01	1.02	1.03	1.04	
1.00 Administrative and General	0	0	300	0	0	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	0	300	0	0	34.00
35.00 Total cost to be allocated	0	0	252	0	0	35.00
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.840000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 150045  
Hospice CCN: 151559

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

Worksheet K-5  
Part II  
Date/Time Prepared:  
2/25/2014 4:27 pm

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 150045

Period:

Worksheet K-5

Hospice CCN: 151559

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

Part II  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		EMPLOYEE	Reconciliation	ADMINISTRATIVE	OPERATION OF	LAUNDRY &	
		BENEFITS		& GENERAL	PLANT	LIEN SERVICE	
		DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF	
		(UNADJUSTED				LAUNDRY)	
		SALARY)	5A	5.00	7.00	8.00	
1.00	Administrative and General	176,569	0	23,626	300	69	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	21,781	0	0	4.00
5.00	Nursing Care	0	0	174,686	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	131	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	79,733	0	0	10.00
11.00	Spiritual Counseling	0	0	5,444	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	32,831	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)	176,569		338,232	300	69	34.00
35.00	Total cost to be allocated	23,374		66,355	9,327	77	35.00
36.00	Unit Cost Multiplier (see instructions)	0.132379		0.196182	31.090000	1.115942	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 150045

Period:

Worksheet K-5

Hospice CCN: 151559

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

Part II  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description	Hospice I					
	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	SNACK BAR (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION  (DIRECT NRS ING)	
	9.00	10.00	10.01	11.00	13.00	
1.00 Administrative and General	300	0	0	273	5,686	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	300	0	0	273	5,686	34.00
35.00 Total cost to be allocated	2,598	0	0	7,550	22,951	35.00
36.00 Unit Cost Multiplier (see instructions)	8.660000	0.000000	0.000000	27.655678	4.036405	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 150045  
Hospice CCN: 151559

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

Worksheet K-5  
Part II  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		Hospice I					
		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)		
		14.00	15.00	16.00	17.00		
1.00	Administrative and General	0	0	773,260	0		1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	0	0	0		4.00
5.00	Nursing Care	0	0	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00	Physical Therapy	0	0	0	0		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0	0		11.00
12.00	Dietary Counseling	0	0	0	0		12.00
13.00	Counseling - Other	0	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00	Other	0	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00	Analgesics	0	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0	0		19.00
20.00	Other - Specify	0	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00	Patient Transportation	0	0	0	0		22.00
23.00	Imaging Services	0	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0	0		24.00
25.00	Medical Supplies	0	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00	Radiation Therapy	0	0	0	0		27.00
28.00	Chemotherapy	0	0	0	0		28.00
29.00	Other	0	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0	0		31.00
32.00	Fundraising	0	0	0	0		32.00
33.00	Other Program Costs	0	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	773,260	0		34.00
35.00	Total cost to be allocated	0	0	8,394	0		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.010855	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 150045

Period: From 10/01/2012

Worksheet K-5

Hospice CCN: 151559

To 09/30/2013

Part III  
Date/Time Prepared:  
2/25/2014 4:27 pm

Cost Center Description		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Hospice I		
				Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.597349	0	0	1.00
1.01	CARDIAC REHAB	66.01	1.231287	0	0	1.01
2.00	OCCUPATIONAL THERAPY	67.00				2.00
3.00	SPEECH PATHOLOGY	68.00				3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.508295	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.262916	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0.302504	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	OTHER ANCILLARY 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: 150045

Period: From 10/01/2012

Worksheet K-6

Hospice CCN: 151559

To 09/30/2013

Date/Time Prepared: 2/25/2014 4:27 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				455,484	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				3,627	2.00
3.00	Average cost per diem (line 1 divided by line 2)				125.58	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	3,609				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	453,218				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)	701				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	88,032				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)			18		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			2,260		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150045	Period: From 10/01/2012 To 09/30/2013	Worksheet L Parts I-III Date/Time Prepared: 2/25/2014 4:27 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		211,425	1.00
2.00	Capital DRG outlier payments		1,131	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		15.21	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		212,556	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00