This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure 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: 140015	Period: From 10/01/2010 To 09/30/2011	Worksheet S Parts I-III Date/Time Prepared: 4/2/2012 1:05 pm

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically filed cost report — Date: 4/2/2012 Time: 1:05 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [ ] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [0] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 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 BLESSING HOSPITAL for the cost reporting period beginning 10/01/2010 and ending 09/30/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement 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 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	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	451,178	-567,974	2,738,294	0	1.00
2.00	Subprovider - IPF	0	42,386	0		0	2.00
3.00	Subprovider - IRF	0	73,474	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	1,554	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		8,933		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	568,592	-559,041	2,738,294	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

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   (2) Settled without Audit
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Encryption Information

ECR: Date: 4/2/2012 Time: 1:05 pm
fH1kjTufriN0RDxRIo9hlOoFtGOyy0
RaDLs0.HAWMIU.qEdjpCfD9RniW46G
8tjt1xNJNE0VxWBH

PI: Date: 4/2/2012 Time: 1:05 pm
hsipftMK0BkB3MP3yuujz3OoAixX61
MX.Ud0r9sU:9ACDMdD5JER5c23N1Ic
jUcQA2iBxY0QrOgr

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

_____
Title

_____
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	451,178	-567,974	2,738,294	0	1.00
2.00	Subprovider - IPF	0	42,386	0		0	2.00
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4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	1,554	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		8,933		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	568,592	-559,041	2,738,294	0	200.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-2 Part I | Date/Time Prepared: 4/2/2012 1:04 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1005 BROADWAY	PO Box:			1.00
2.00	City: QUINCY	State: IL	Zip Code: 62301	County: ADAMS	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	BLESSING HOSPITAL	140015	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	BLESSING PSYCHIATRIC UNIT 14TH ST	14S015	99914	4	10/01/1993	N	P	N	4.00
5.00	Subprovider - IRF	BLESSING REHAB UNIT	14T015	99914	5	10/01/1985	N	P	N	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF						N	N	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF	BLESSING SKILLED CARE UNIT	145643	99914		06/20/1989	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	BLESSING HOME CARE	147031	99914		12/01/1984	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HOSPICE OF ADAMS COUNTY	141501	99914		06/01/1984				14.00
15.00	Hospital-Based Health Clinic - RHC	GOLDEN CLINIC	143422	99914		09/08/1996	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2010	09/30/2011	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of State Medicaid paid days	Out-of State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	9,910	0	1,665	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	442	0	51	0	0	0	25.00

		1.00	
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 (1) for urban or (2) for rural.	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.	1	35.00

		Beginning:	Ending:	
		1.00	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.	10/01/2010	09/30/2011	36.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140015	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 4/2/2012 1:04 pm

		Beginning:	Ending:	
		1.00	2.00	
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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y			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.	N			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)	Y			60.00

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	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.				
64.00	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	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-2 Part I Date/Time Prepared: 4/2/2012 1:04 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1 the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations 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	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N	N	0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.	N	80.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140015	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 4/2/2012 1:04 pm

		1.00	
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	N	86.00

		V	XIX	
		1.00	2.00	
	Title V or XIX Inpatient Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	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)			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			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	
	Miscellaneous Cost Reporting Information			
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.	N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y		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
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.	1,500,000	5,500,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? 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? Enter in column 2 "Y" for yes or "N" for no.	Y	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-2 Part I Date/Time Prepared: 4/2/2012 1:04 pm

		1.00	2.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H132	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: BLESSING CORPORATE SERVICES	Contractor's Name: NATIONAL GOVERNMENT SERVICES	Contractor's Number: 131	141.00
142.00	Street: BROADWAY AT 11TH STREET	PO Box:		142.00
143.00	City: QUINCY	State: IL	Zip Code: 62301	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, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	Y	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	
		1.00	2.00	
	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	155.00
156.00	Subprovider - IPF	N	N	156.00
157.00	Subprovider - IRF	N	N	157.00
158.00	SUBPROVIDER	N	N	158.00
159.00	SNF	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	160.00
161.00	CMHC		N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		0 Name	1.00 County	2.00 State	3.00 Zip Code	4.00 CBSA	5.00 FTE/Campus	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	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)	1.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-2 Part II | Date/Time Prepared: 4/2/2012 1:04 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)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	Y	Y	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		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.	Y		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		
		Description	Y/N	Date	
		0	1.00	2.00	
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		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)		Y	02/29/2012	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-2 Part II Date/Time Prepared: 4/2/2012 1:04 pm

		Description	Part A Y/N	Part A Date		
		0	1.00	2.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N			21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N/A	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		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.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			Y		40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-2 Part II Date/Time Prepared: 4/2/2012 1:04 pm

		Part B		
		Y/N	Date	
		3.00	4.00	
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		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)	Y	01/31/2012	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours		
		1.00	2.00	3.00	4.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	164	59,860	0.00		1.00
2.00	HMO						2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						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)		164	59,860	0.00		7.00
8.00	INTENSIVE CARE UNIT	31.00	25	9,125	0.00		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00					13.00
14.00	Total (see instructions)		189	68,985	0.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	40.00	60	21,900			16.00
17.00	SUBPROVIDER - IRF	41.00	18	6,570			17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	20	7,300			19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		287				27.00
28.00	Observation Bed Days						28.00
28.01	SUBPROVIDER - IPF	40.00					28.01
28.02	SUBPROVIDER - IRF	41.00					28.02
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	I/P Days / O/P Visits / Trips					
		Title V	Title XVIII	Title XIX	Total All Patients		
		5.00	6.00	7.00	8.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	24,041	5,173	37,309		1.00
2.00	HMO		384	0			2.00
3.00	HMO IPF		0	0			3.00
4.00	HMO IRF		0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	24,041	5,173	37,309		7.00
8.00	INTENSIVE CARE UNIT	0	2,819	557	5,488		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		1,411	2,450		13.00
14.00	Total (see instructions)	0	26,860	7,141	45,247		14.00
15.00	CAH visits	0	0	0	0		15.00
16.00	SUBPROVIDER - IPF	0	1,507	3,941	9,347		16.00
17.00	SUBPROVIDER - IRF	0	3,196	493	4,835		17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	4,882	0	5,896		19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	12,308	0	22,772		22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE		0	0	0		24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	0	0	7,604		26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)						27.00
28.00	Observation Bed Days	0		1,041	6,605		28.00
28.01	SUBPROVIDER - IPF				0		28.01
28.02	SUBPROVIDER - IRF				0		28.02
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				1,200		30.00
31.00	Employee discount days - IRF				64		31.00
32.00	Labor & delivery days (see instructions)			0	0		32.00
33.00	LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-3 Part I Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	Full Time Equivalents			Discharges		
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
		9.00	10.00	11.00	12.00	13.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	5,910	1.00
2.00	HMO					95	2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						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)	17.04	1,753.75	0.00	0	5,910	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.33	28.57	0.00	0	219	16.00
17.00	SUBPROVIDER - IRF	0.46	69.57	0.00	0	241	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00	32.07	0.00			19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00	28.94	0.00			22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00	31.70	0.00			24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00	7.57	0.00			26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	17.83	1,952.17	0.00			27.00
28.00	Observation Bed Days						28.00
28.01	SUBPROVIDER - IPF						28.01
28.02	SUBPROVIDER - IRF						28.02
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	Discharges			
		Title XIX	Total All Patients		
		14.00	15.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	3,055	11,057		1.00
2.00	HMO				2.00
3.00	HMO IPF				3.00
4.00	HMO IRF				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)	3,055	11,057		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF	1,102	1,588		16.00
17.00	SUBPROVIDER - IRF	60	363		17.00
18.00	SUBPROVIDER				18.00
19.00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE				21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00	HOSPICE				24.00
25.00	CMHC - CMHC				25.00
26.00	RURAL HEALTH CLINIC				26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
28.01	SUBPROVIDER - IPF				28.01
28.02	SUBPROVIDER - IRF				28.02
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days - IRF				31.00
32.00	Labor & delivery days (see instructions)				32.00
33.00	LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-3 Part II Date/Time Prepared: 4/2/2012 1:04 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	
		1.00	2.00	3.00	4.00	5.00	
	PART II - WAGE DATA						
	SALARIES						
1.00	Total salaries (see instructions)	200.00	100,013,564	0	100,013,564	4,061,902.02	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	3.00
4.00	Physician-Part A		270,773	0	270,773	1,766.66	4.00
4.01	Physicians - Part A - direct teaching		0	0	0	0.00	4.01
5.00	Physician-Part B		6,238,259	0	6,238,259	27,452.67	5.00
6.00	Non-physician-Part B		600,562	0	600,562	20,997.26	6.00
7.00	Interns & residents (in an approved program)	21.00	1,012,486	0	1,012,486	39,855.20	7.00
7.01	Contracted interns and residents (in approved programs)		0	0	0	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	8.00
9.00	SNF	44.00	1,425,533	-1,133	1,424,400	66,915.75	9.00
10.00	Excluded area salaries (see instructions)		13,602,699	488,712	14,091,411	511,344.18	10.00
	OTHER WAGES & RELATED COSTS						
11.00	Contract labor (see instructions)		256,867	0	256,867	3,826.27	11.00
12.00	Management and administrative services		317,809	0	317,809	1,812.54	12.00
13.00	Contract labor: physician-Part A		0	0	0	0.00	13.00
14.00	Home office salaries & wage-related costs		4,748,197	0	4,748,197	59,176.62	14.00
15.00	Home office: physician Part A		0	0	0	0.00	15.00
16.00	Teaching physician salaries (see instructions)		0	0	0	0.00	16.00
	WAGE-RELATED COSTS						
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		26,656,769	0	26,656,769		17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25		0	0	0		18.00
19.00	Excluded areas		4,826,506	0	4,826,506		19.00
20.00	Non-physician anesthetist Part A		0	0	0		20.00
21.00	Non-physician anesthetist Part B		0	0	0		21.00
22.00	Physician Part A		42,255	0	42,255		22.00
23.00	Physician Part B		906,224	0	906,224		23.00
24.00	Wage-related costs (RHC/FQHC)		180,200	0	180,200		24.00
25.00	Interns & residents (in an approved program)		326,452	0	326,452		25.00
	OVERHEAD COSTS - DIRECT SALARIES						
26.00	Employee Benefits	4.00	2,336,956	0	2,336,956	157,802.99	26.00
27.00	Administrative & General	5.00	11,669,208	0	11,669,208	469,478.91	27.00
28.00	Administrative & General under contract (see inst.)		317,809	0	317,809	1,812.54	28.00
29.00	Maintenance & Repairs	6.00	2,397,112	0	2,397,112	119,704.44	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	30.00
31.00	Laundry & Linen Service	8.00	61,019	0	61,019	5,432.92	31.00
32.00	Housekeeping	9.00	2,075,381	0	2,075,381	168,628.28	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	33.00
34.00	Dietary	10.00	2,179,963	-1,378,609	801,354	63,793.69	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	35.00
36.00	Cafeteria	11.00	0	1,378,609	1,378,609	110,950.88	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	37.00
38.00	Nursing Administration	13.00	4,797,005	-14,713	4,782,292	189,290.79	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	1,670,414	0	1,670,414	107,978.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-3 Part II Date/Time Prepared: 4/2/2012 1:04 pm

		Average Hourly Wage (col. 4 ÷ col. 5)		
		6.00		
	PART II - WAGE DATA			
	SALARIES			
1.00	Total salaries (see instructions)	24.62		1.00
2.00	Non-physician anesthetist Part A	0.00		2.00
3.00	Non-physician anesthetist Part B	0.00		3.00
4.00	Physician-Part A	153.27		4.00
4.01	Physicians - Part A - direct teaching	0.00		4.01
5.00	Physician-Part B	227.24		5.00
6.00	Non-physician-Part B	28.60		6.00
7.00	Interns & residents (in an approved program)	25.40		7.00
7.01	Contracted interns and residents (in approved programs)	0.00		7.01
8.00	Home office personnel	0.00		8.00
9.00	SNF	21.29		9.00
10.00	Excluded area salaries (see instructions)	27.56		10.00
	OTHER WAGES & RELATED COSTS			
11.00	Contract labor (see instructions)	67.13		11.00
12.00	Management and administrative services	175.34		12.00
13.00	Contract labor: physician-Part A	0.00		13.00
14.00	Home office salaries & wage-related costs	80.24		14.00
15.00	Home office: physician Part A	0.00		15.00
16.00	Teaching physician salaries (see instructions)	0.00		16.00
	WAGE-RELATED COSTS			
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24			17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25			18.00
19.00	Excluded areas			19.00
20.00	Non-physician anesthetist Part A			20.00
21.00	Non-physician anesthetist Part B			21.00
22.00	Physician Part A			22.00
23.00	Physician Part B			23.00
24.00	Wage-related costs (RHC/FQHC)			24.00
25.00	Interns & residents (in an approved program)			25.00
	OVERHEAD COSTS - DIRECT SALARIES			
26.00	Employee Benefits	14.81		26.00
27.00	Administrative & General	24.86		27.00
28.00	Administrative & General under contract (see inst.)	175.34		28.00
29.00	Maintenance & Repairs	20.03		29.00
30.00	Operation of Plant	0.00		30.00
31.00	Laundry & Linen Service	11.23		31.00
32.00	Housekeeping	12.31		32.00
33.00	Housekeeping under contract (see instructions)	0.00		33.00
34.00	Dietary	12.56		34.00
35.00	Dietary under contract (see instructions)	0.00		35.00
36.00	Cafeteria	12.43		36.00
37.00	Maintenance of Personnel	0.00		37.00
38.00	Nursing Administration	25.26		38.00
39.00	Central Services and Supply	0.00		39.00
40.00	Pharmacy	0.00		40.00
41.00	Medical Records & Medical Records Library	15.47		41.00
42.00	Social Service	0.00		42.00
43.00	Other General Service	0.00		43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-3 Part III Date/Time Prepared: 4/2/2012 1:04 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	
		1.00	2.00	3.00	4.00	5.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY						
1.00	Net salaries (see instructions)		92,480,066	0	92,480,066	3,975,409.43	1.00
2.00	Excluded area salaries (see instructions)		15,028,232	487,579	15,515,811	578,259.93	2.00
3.00	Subtotal salaries (line 1 minus line 2)		77,451,834	-487,579	76,964,255	3,397,149.50	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,322,873	0	5,322,873	64,815.43	4.00
5.00	Subtotal wage-related costs (see inst.)		26,699,024	0	26,699,024	0.00	5.00
6.00	Total (sum of lines 3 thru 5)		109,473,731	-487,579	108,986,152	3,461,964.93	6.00
7.00	Total overhead cost (see instructions)		27,504,867	-14,713	27,490,154	1,394,873.44	7.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-3 Part III Date/Time Prepared: 4/2/2012 1:04 pm

		Average Hourly Wage (col. 4 ÷ col. 5)		
		6.00		
	PART III - HOSPITAL WAGE INDEX SUMMARY			
1.00	Net salaries (see instructions)	23.26		1.00
2.00	Excluded area salaries (see instructions)	26.83		2.00
3.00	Subtotal salaries (line 1 minus line 2)	22.66		3.00
4.00	Subtotal other wages & related costs (see inst.)	82.12		4.00
5.00	Subtotal wage-related costs (see inst.)	34.69		5.00
6.00	Total (sum of lines 3 thru 5)	31.48		6.00
7.00	Total overhead cost (see instructions)	19.71		7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-3 Part IV Date/Time Prepared: 4/2/2012 1:04 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,418,901	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	2,769,264	3.00
4.00	Prior Year Pension Service Cost	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	18,253,709	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)	116,860	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	256,099	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,814,251	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	6,540,458	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	227,182	20.00
	OTHER		
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	541,682	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	32,938,406	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-3 Part V Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	256,867	0	1.00
2.00	Hospital	256,867	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00		0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 140015 | Component CCN: 147031 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-4 | Date/Time Prepared: 4/2/2012 1:04 pm

Home Health Agency I | PPS

		1.00	
0.00	County	ADAMS	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	4,441	0	2,310	6,751	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	535.00	0.00	701.00	1,236.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		1.01	0.00	1.01	4.00
5.00	Other Administrative Personnel		6.18	0.00	6.18	5.00
6.00	Direct Nursing Service		14.08	0.00	14.08	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		3.34	0.00	3.34	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.10	0.00	0.10	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.85	0.00	0.85	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.13	0.00	0.13	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		3.25	0.00	3.25	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99914			20.00
20.01			99926			20.01

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	4,503	2,211	167	94	6,975	21.00
22.00	Skilled Nursing Visit Charges	661,941	325,017	24,549	13,818	1,025,325	22.00
23.00	Physical Therapy Visits	2,011	32	49	24	2,116	23.00
24.00	Physical Therapy Visit Charges	295,617	4,704	7,203	3,528	311,052	24.00
25.00	Occupational Therapy Visits	473	18	6	2	499	25.00
26.00	Occupational Therapy Visit Charges	69,531	2,646	882	294	73,353	26.00
27.00	Speech Pathology Visits	104	0	2	0	106	27.00
28.00	Speech Pathology Visit Charges	15,288	0	294	0	15,582	28.00
29.00	Medical Social Service Visits	2	1	0	0	3	29.00
30.00	Medical Social Service Visit Charges	294	147	0	0	441	30.00
31.00	Home Health Aide Visits	1,695	913	1	0	2,609	31.00
32.00	Home Health Aide Visit Charges	138,990	74,866	82	0	213,938	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	8,788	3,175	225	120	12,308	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)	1,181,661	407,380	33,010	17,640	1,639,691	35.00
36.00	Total Number of Episodes (standard/non outlier)	574		78	10	662	36.00
37.00	Total Number of Outlier Episodes		52		0	52	37.00
38.00	Total Non-Routine Medical Supply Charges	16,175	8,571	1,126	143	26,015	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-7 | Date/Time Prepared: 4/2/2012 1:04 pm

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	8	0	8	4.00
5.00		RVX	6	0	6	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	130	0	130	7.00
8.00		RHL	192	0	192	8.00
9.00		RMX	235	0	235	9.00
10.00		RML	238	0	238	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	19	0	19	15.00
16.00		RVB	18	0	18	16.00
17.00		RVA	11	0	11	17.00
18.00		RHC	448	0	448	18.00
19.00		RHB	242	0	242	19.00
20.00		RHA	731	0	731	20.00
21.00		RMC	424	0	424	21.00
22.00		RMB	266	0	266	22.00
23.00		RMA	1,045	0	1,045	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	10	0	10	27.00
28.00		ES1	149	0	149	28.00
29.00		HE2	6	0	6	29.00
30.00		HE1	25	0	25	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	68	0	68	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	48	0	48	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	214	0	214	36.00
37.00		LE2	2	0	2	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	9	0	9	40.00
41.00		LC2	5	0	5	41.00
42.00		LC1	22	0	22	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	17	0	17	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	4	0	4	46.00
47.00		CD2	6	0	6	47.00
48.00		CD1	39	0	39	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	14	0	14	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	139	0	139	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	71	0	71	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	1	0	1	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	5	0	5	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-7 | Date/Time Prepared: 4/2/2012 1:04 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	4	0	4	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	11	0	11	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		4,882	0	4,882	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99914	99914	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	1,425,533	32.78	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	4,349,406			207.00

		1.00	
1.00	Wage Index Factor	0.8343	1.00

		Group	Base Rate Prior to 10/1	Actual Rate for Services Prior to 10/1	Days for Services Prior to 10/1	Base Rate On/After 10/1	
		1.00	2.00	3.00	4.00	5.00	
3.00		RUX	778.69	778.69	0	778.69	3.00
4.00		RUL	760.00	760.00	0	760.00	4.00
5.00		RVX	696.41	696.41	0	696.41	5.00
6.00		RVL	621.67	621.67	0	621.67	6.00
7.00		RHX	633.56	633.56	0	633.56	7.00
8.00		RHL	561.49	561.49	0	561.49	8.00
9.00		RMX	581.14	581.14	0	581.14	9.00
10.00		RML	533.09	533.09	0	533.09	10.00
11.00		RLX	452.34	452.34	0	452.34	11.00
12.00		RUC	579.81	579.81	0	579.81	12.00
13.00		RUB	579.81	579.81	0	579.81	13.00
14.00		RUA	477.03	477.03	0	477.03	14.00
15.00		RVC	497.54	497.54	0	497.54	15.00
16.00		RVB	426.80	426.80	0	426.80	16.00
17.00		RVA	425.47	425.47	0	425.47	17.00
18.00		RHC	434.69	434.69	0	434.69	18.00
19.00		RHB	389.31	389.31	0	389.31	19.00
20.00		RHA	339.92	339.92	0	339.92	20.00
21.00		RMC	383.61	383.61	0	383.61	21.00
22.00		RMB	356.92	356.92	0	356.92	22.00
23.00		RMA	290.17	290.17	0	290.17	23.00
24.00		RLB	374.87	374.87	0	374.87	24.00
25.00		RLA	233.39	233.39	0	233.39	25.00
26.00		ES3	565.25	565.25	0	565.25	26.00
27.00		ES2	443.79	443.79	0	443.79	27.00
28.00		ES1	397.07	397.07	0	397.07	28.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-7 | Date/Time Prepared: 4/2/2012 1:04 pm

		Group	Base Rate Prior to 10/1	Actual Rate for Services Prior to 10/1	Days for Services Prior to 10/1	Base Rate On/After 10/1	
		1.00	2.00	3.00	4.00	5.00	
29.00		HE2	383.72	383.72	0	383.72	29.00
30.00		HE1	319.66	319.66	0	319.66	30.00
31.00		HD2	359.70	359.70	0	359.70	31.00
32.00		HD1	300.97	300.97	0	300.97	32.00
33.00		HC2	339.68	339.68	0	339.68	33.00
34.00		HC1	284.96	284.96	0	284.96	34.00
35.00		HB2	335.68	335.68	0	335.68	35.00
36.00		HB1	282.28	282.28	0	282.28	36.00
37.00		LE2	349.02	349.02	0	349.02	37.00
38.00		LE1	292.97	292.97	0	292.97	38.00
39.00		LD2	335.68	335.68	0	335.68	39.00
40.00		LD1	282.28	282.28	0	282.28	40.00
41.00		LC2	295.63	295.63	0	295.63	41.00
42.00		LC1	250.25	250.25	0	250.25	42.00
43.00		LB2	280.96	280.96	0	280.96	43.00
44.00		LB1	239.57	239.57	0	239.57	44.00
45.00		CE2	311.65	311.65	0	311.65	45.00
46.00		CE1	287.63	287.63	0	287.63	46.00
47.00		CD2	295.63	295.63	0	295.63	47.00
48.00		CD1	271.61	271.61	0	271.61	48.00
49.00		CC2	259.60	259.60	0	259.60	49.00
50.00		CC1	240.91	240.91	0	240.91	50.00
51.00		CB2	240.91	240.91	0	240.91	51.00
52.00		CB1	223.56	223.56	0	223.56	52.00
53.00		CA2	204.88	204.88	0	204.88	53.00
54.00		CA1	191.53	191.53	0	191.53	54.00
55.00		SE3	0.00	0.00	0	0.00	55.00
56.00		SE2	0.00	0.00	0	0.00	56.00
57.00		SE1	0.00	0.00	0	0.00	57.00
58.00		SSC	0.00	0.00	0	0.00	58.00
59.00		SSB	0.00	0.00	0	0.00	59.00
60.00		SSA	0.00	0.00	0	0.00	60.00
61.00		IB2	0.00	0.00	0	0.00	61.00
62.00		IB1	0.00	0.00	0	0.00	62.00
63.00		IA2	0.00	0.00	0	0.00	63.00
64.00		IA1	0.00	0.00	0	0.00	64.00
65.00		BB2	216.89	216.89	0	216.89	65.00
66.00		BB1	207.54	207.54	0	207.54	66.00
67.00		BA2	180.85	180.85	0	180.85	67.00
68.00		BA1	172.84	172.84	0	172.84	68.00
69.00		PE2	287.63	287.63	0	287.63	69.00
70.00		PE1	274.28	274.28	0	274.28	70.00
71.00		PD2	271.61	271.61	0	271.61	71.00
72.00		PD1	258.26	258.26	0	258.26	72.00
73.00		PC2	234.24	234.24	0	234.24	73.00
74.00		PC1	223.56	223.56	0	223.56	74.00
75.00		PB2	199.53	199.53	0	199.53	75.00
76.00		PB1	191.53	191.53	0	191.53	76.00
77.00		PA2	166.17	166.17	0	166.17	77.00
78.00		PA1	159.50	159.50	0	159.50	78.00
199.00		AAA	0.00	0.00	0	0.00	199.00
200.00	TOTAL				0		200.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-7 | Date/Time Prepared: 4/2/2012 1:04 pm

		Actual Rate for Services On/After 10/1	Days for Services On/After 10/1	Total		
		6.00	7.00	8.00		
3.00		778.69	0	0		3.00
4.00		760.00	0	0		4.00
5.00		696.41	0	0		5.00
6.00		621.67	0	0		6.00
7.00		633.56	0	0		7.00
8.00		561.49	0	0		8.00
9.00		581.14	0	0		9.00
10.00		533.09	0	0		10.00
11.00		452.34	0	0		11.00
12.00		579.81	0	0		12.00
13.00		579.81	0	0		13.00
14.00		477.03	0	0		14.00
15.00		497.54	0	0		15.00
16.00		426.80	0	0		16.00
17.00		425.47	0	0		17.00
18.00		434.69	0	0		18.00
19.00		389.31	0	0		19.00
20.00		339.92	0	0		20.00
21.00		383.61	0	0		21.00
22.00		356.92	0	0		22.00
23.00		290.17	0	0		23.00
24.00		374.87	0	0		24.00
25.00		233.39	0	0		25.00
26.00		565.25	0	0		26.00
27.00		443.79	0	0		27.00
28.00		397.07	0	0		28.00
29.00		383.72	0	0		29.00
30.00		319.66	0	0		30.00
31.00		359.70	0	0		31.00
32.00		300.97	0	0		32.00
33.00		339.68	0	0		33.00
34.00		284.96	0	0		34.00
35.00		335.68	0	0		35.00
36.00		282.28	0	0		36.00
37.00		349.02	0	0		37.00
38.00		292.97	0	0		38.00
39.00		335.68	0	0		39.00
40.00		282.28	0	0		40.00
41.00		295.63	0	0		41.00
42.00		250.25	0	0		42.00
43.00		280.96	0	0		43.00
44.00		239.57	0	0		44.00
45.00		311.65	0	0		45.00
46.00		287.63	0	0		46.00
47.00		295.63	0	0		47.00
48.00		271.61	0	0		48.00
49.00		259.60	0	0		49.00
50.00		240.91	0	0		50.00
51.00		240.91	0	0		51.00
52.00		223.56	0	0		52.00
53.00		204.88	0	0		53.00
54.00		191.53	0	0		54.00
55.00		0.00	0	0		55.00
56.00		0.00	0	0		56.00
57.00		0.00	0	0		57.00
58.00		0.00	0	0		58.00
59.00		0.00	0	0		59.00
60.00		0.00	0	0		60.00
61.00		0.00	0	0		61.00
62.00		0.00	0	0		62.00
63.00		0.00	0	0		63.00
64.00		0.00	0	0		64.00
65.00		216.89	0	0		65.00
66.00		207.54	0	0		66.00
67.00		180.85	0	0		67.00
68.00		172.84	0	0		68.00
69.00		287.63	0	0		69.00
70.00		274.28	0	0		70.00
71.00		271.61	0	0		71.00
72.00		258.26	0	0		72.00
73.00		234.24	0	0		73.00
74.00		223.56	0	0		74.00
75.00		199.53	0	0		75.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-7 | Date/Time Prepared: 4/2/2012 1:04 pm

		Actual Rate for Services On/After 10/1	Days for Services On/After 10/1	Total		
		6.00	7.00	8.00		
76.00		191.53	0	0		76.00
77.00		166.17	0	0		77.00
78.00		159.50	0	0		78.00
199.00		0.00	0	0		199.00
200.00	TOTAL		0	0		200.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 140015 Component CCN: 143422 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-8 | Date/Time Prepared: 4/2/2012 1:04 pm

			Rural Health Clinic (RHC) I	Cost	
			1.00		
	Clinic Address and Identification				
1.00	Street		102 PRARIE MILLS ROAD		1.00
		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	GOLDEN	IL	62339	2.00
				1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
			Grant Award	Date	
			1.00	2.00	
	Source of Federal Funds				
4.00	Community Health Center (Section 330(d), PHS Act)		0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)		0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		0		6.00
7.00	Appalachian Regional Commission		0		7.00
8.00	Look-Alikes		0		8.00
9.00	OTHER (SPECIFY)		0		9.00
			1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0	10.00

		Sunday		Monday			
		from	to	from	to		
		1.00	2.00	3.00	4.00		
	Facility hours of operations (1)						
11.00	Clinic			09:00	17:00		11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

			Provider name		CCN number	
			1.00		2.00	
14.00	Provider name, CCN number					14.00

		Y/N	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)	N	0	0	0	15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 140015 Component CCN: 143422

Period: From 10/01/2010 To 09/30/2011

Worksheet S-8

Date/Time Prepared: 4/2/2012 1:04 pm

Rural Health Clinic (RHC) I

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		ADAMS				2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	17:00	09:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 140015
Component CCN: 143422

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-8

Date/Time Prepared:
4/2/2012 1:04 pm

Rural Health Clinic (RHC) I

Cost

		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	17:00	09:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 140015
Component CCN: 143422

Period: From 10/01/2010 To 09/30/2011

Worksheet S-8

Date/Time Prepared: 4/2/2012 1:04 pm

		Rural Health Clinic (RHC) I	Cost
		Saturday	
		from	to
		13.00	14.00
	Facility hours of operations (1)		
11.00	Clinic		11.00

HOSPITAL IDENTIFICATION DATA	Provider CCN: 140015 Component CCN: 141501	Period: From 10/01/2010 To 09/30/2011	Worksheet S-9 Parts I & II Date/Time Prepared: 4/2/2012 1:04 pm

Hospice I

		Unduplicated Days					
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ENROLLMENT DAYS						
1.00	Continuous Home Care	0	0	0	0	0	1.00
2.00	Routine Home Care	16,245	935	0	820	820	2.00
3.00	Inpatient Respite Care	7	0	0	0	0	3.00
4.00	General Inpatient Care	106	17	0	0	39	4.00
5.00	Total Hospice Days	16,358	952	0	820	859	5.00
	Part II - CENSUS DATA						
6.00	Number of Patients Receiving Hospice Care	455	23	0	11	39	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)	35.95	41.39	0.00	74.55	22.03	8.00
9.00	Unduplicated Census Count	445	23	0	11	39	9.00

HOSPITAL IDENTIFICATION DATA	Provider CCN: 140015 Component CCN: 141501	Period: From 10/01/2010 To 09/30/2011	Worksheet S-9 Parts I & II Date/Time Prepared: 4/2/2012 1:04 pm

Hospice I

		Unduplicated Days Total (sum of cols. 1, 2 & 5)		
		6.00		
	PART I - ENROLLMENT DAYS			
1.00	Continuous Home Care	0		1.00
2.00	Routine Home Care	18,000		2.00
3.00	Inpatient Respite Care	7		3.00
4.00	General Inpatient Care	162		4.00
5.00	Total Hospice Days	18,169		5.00
	Part II - CENSUS DATA			
6.00	Number of Patients Receiving Hospice Care	517		6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare			7.00
8.00	Average Length of Stay (line 5/line 6)	35.14		8.00
9.00	Unduplicated Census Count	507		9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-10 | Date/Time Prepared: 4/2/2012 1:04 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)	0.300092	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	11,799,216	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	6,518,419	5.00
6.00	Medicaid charges	51,149,893	6.00
7.00	Medicaid cost (line 1 times line 6)	15,349,674	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		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	23,415,500	24,789,304	48,204,804	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	7,026,804	7,439,072	14,465,876	21.00
22.00	Partial payment by patients approved for charity care	155,885	130,893	286,778	22.00
23.00	Cost of charity care (line 21 minus line 22)	6,870,919	7,308,179	14,179,098	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)	20,080,401	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	1,076,114	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	19,004,287	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	5,703,034	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	19,882,132	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	19,882,132	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A | Date/Time Prepared: 4/2/2012 1:04 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	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT		0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING		3,951	3,951	22,229	26,180	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT		247,800	247,800	42,696	290,496	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT		3,303,639	3,303,639	85,943	3,389,582	1.03
1.04	CAP REL COSTS-14TH STREET		341,741	341,741	1,852,601	2,194,342	1.04
1.05	CAP REL COSTS-MOB PHASE I		0	0	216,519	216,519	1.05
2.00	CAP REL COSTS-MVBLE EQUIP		10,335,935	10,335,935	618,897	10,954,832	2.00
3.00	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	EMPLOYEE BENEFITS	2,336,956	37,245,971	39,582,927	0	39,582,927	4.00
5.00	ADMINISTRATIVE & GENERAL	11,669,208	47,969,750	59,638,958	382,493	60,021,451	5.00
6.00	MAINTENANCE & REPAIRS	2,397,112	4,033,742	6,430,854	0	6,430,854	6.00
8.00	LAUNDRY & LINEN SERVICE	61,019	950,945	1,011,964	0	1,011,964	8.00
9.00	HOUSEKEEPING	2,075,381	396,697	2,472,078	0	2,472,078	9.00
10.00	DIETARY	2,179,963	3,333,783	5,513,746	-3,486,893	2,026,853	10.00
11.00	CAFETERIA	0	0	0	3,486,893	3,486,893	11.00
13.00	NURSING ADMINISTRATION	4,797,005	751,223	5,548,228	-14,757	5,533,471	13.00
16.00	MEDICAL RECORDS & LIBRARY	1,670,414	846,445	2,516,859	0	2,516,859	16.00
20.00	NURSING SCHOOL	2,371,669	1,103,134	3,474,803	801,285	4,276,088	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	1,012,486	0	1,012,486	0	1,012,486	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,219,351	1,219,351	0	1,219,351	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
23.01	PARAMED ED PRGM-RADIOLOGY	230,179	7,566	237,745	0	237,745	23.01
23.02	PARAMED ED PRGM-LABORATORY	74,690	2,493	77,183	0	77,183	23.02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	14,377,779	1,107,952	15,485,731	-632,337	14,853,394	30.00
31.00	INTENSIVE CARE UNIT	3,818,651	467,128	4,285,779	-249,307	4,036,472	31.00
40.00	SUBPROVIDER - IPF	3,264,354	78,716	3,343,070	-33,091	3,309,979	40.00
41.00	SUBPROVIDER - IRF	1,384,023	244,304	1,628,327	-13,312	1,615,015	41.00
43.00	NURSERY	446,660	76,837	523,497	-56,829	466,668	43.00
44.00	SKILLED NURSING FACILITY	1,425,533	125,078	1,550,611	-24,669	1,525,942	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	7,702,319	15,983,934	23,686,253	-11,215,111	12,471,142	50.00
52.00	DELIVERY ROOM & LABOR ROOM	1,152,668	219,110	1,371,778	-82,199	1,289,579	52.00
53.00	ANESTHESIOLOGY	159,862	409,316	569,178	-238,479	330,699	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,646,293	3,351,564	7,997,857	-323,703	7,674,154	54.00
60.00	LABORATORY	3,043,849	2,554,428	5,598,277	-36,312	5,561,965	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	209,200	1,224,274	1,433,474	0	1,433,474	62.00
65.00	RESPIRATORY THERAPY	1,896,744	347,075	2,243,819	-98,866	2,144,953	65.00
66.00	PHYSICAL THERAPY	1,989,551	248,398	2,237,949	259,669	2,497,618	66.00
67.00	OCCUPATIONAL THERAPY	656,347	9,420	665,767	68,480	734,247	67.00
68.00	SPEECH PATHOLOGY	243,968	6,101	250,069	5,992	256,061	68.00
69.00	ELECTROCARDIOLOGY	1,444,131	3,813,224	5,257,355	-2,827,234	2,430,121	69.00
70.00	ELECTROENCEPHALOGRAPHY	284,164	87,586	371,750	-86	371,664	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	670,405	539,734	1,210,139	6,049,891	7,260,030	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,965,435	8,965,435	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,986,582	13,132,536	16,119,118	-328	16,118,790	73.00
74.00	RENAL DIALYSIS	0	676,842	676,842	-405	676,437	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	352,429	406,558	758,987	-1,125	757,862	88.00
91.00	EMERGENCY	10,704,186	1,453,341	12,157,527	-128,282	12,029,245	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	1,566,079	410,612	1,976,691	-352,693	1,623,998	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE		3,056,659	3,056,659	-3,056,659	0	113.00
116.00	HOSPICE	1,572,171	572,981	2,145,152	-1,103	2,144,049	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	96,874,030	162,697,874	259,571,904	-14,757	259,557,147	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	2,584,084	68,683	2,652,767	0	2,652,767	192.00
192.01	FASTCARE	394,582	100,541	495,123	0	495,123	192.01
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	ADULT DAY CARE	0	0	0	0	0	193.01
193.02	DENMAN SERVICES	0	0	0	0	0	193.02
193.03	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	UNUSED SPACE	0	0	0	0	0	193.04
193.05	HEALTH EDUCATION	0	0	0	14,757	14,757	193.05
193.06	RENTED SPACE	0	0	0	0	0	193.06
193.07	AUGUSTA PHARMACY	160,868	847,094	1,007,962	0	1,007,962	193.07
200.00	TOTAL (SUM OF LINES 118-199)	100,013,564	163,714,192	263,727,756	0	263,727,756	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0		1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	26,180		1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	0	290,496		1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	-121,662	3,267,920		1.03
1.04	CAP REL COSTS-14TH STREET	-2,107,195	87,147		1.04
1.05	CAP REL COSTS-MOB PHASE I	-159,182	57,337		1.05
2.00	CAP REL COSTS-MVBLE EQUIP	-765,943	10,188,889		2.00
3.00	OTHER CAP REL COSTS	0	0		3.00
4.00	EMPLOYEE BENEFITS	-17,824,300	21,758,627		4.00
5.00	ADMINISTRATIVE & GENERAL	-27,133,346	32,888,105		5.00
6.00	MAINTENANCE & REPAIRS	-470,002	5,960,852		6.00
8.00	LAUNDRY & LINEN SERVICE	59,587	1,071,551		8.00
9.00	HOUSEKEEPING	-236,586	2,235,492		9.00
10.00	DIETARY	-160,399	1,866,454		10.00
11.00	CAFETERIA	-1,286,267	2,200,626		11.00
13.00	NURSING ADMINISTRATION	-151,731	5,381,740		13.00
16.00	MEDICAL RECORDS & LIBRARY	-52,795	2,464,064		16.00
20.00	NURSING SCHOOL	-2,740,573	1,535,515		20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,012,486		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,219,351		22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0		23.00
23.01	PARAMED ED PRGM-RADIOLOGY	-74,150	163,595		23.01
23.02	PARAMED ED PRGM-LABORATORY	-19,587	57,596		23.02
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-18,047	14,835,347		30.00
31.00	INTENSIVE CARE UNIT	-13,874	4,022,598		31.00
40.00	SUBPROVIDER - IPF	0	3,309,979		40.00
41.00	SUBPROVIDER - IRF	-12,718	1,602,297		41.00
43.00	NURSERY	0	466,668		43.00
44.00	SKILLED NURSING FACILITY	-530	1,525,412		44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-882,062	11,589,080		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	1,289,579		52.00
53.00	ANESTHESIOLOGY	0	330,699		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	7,674,154		54.00
60.00	LABORATORY	-74,386	5,487,579		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,433,474		62.00
65.00	RESPIRATORY THERAPY	-14,014	2,130,939		65.00
66.00	PHYSICAL THERAPY	-260	2,497,358		66.00
67.00	OCCUPATIONAL THERAPY	0	734,247		67.00
68.00	SPEECH PATHOLOGY	0	256,061		68.00
69.00	ELECTROCARDIOLOGY	-24,315	2,405,806		69.00
70.00	ELECTROENCEPHALOGRAPHY	-33,611	338,053		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,260,030		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	8,965,435		72.00
73.00	DRUGS CHARGED TO PATIENTS	-2,486,953	13,631,837		73.00
74.00	RENAL DIALYSIS	0	676,437		74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	-17,990	739,872		88.00
91.00	EMERGENCY	-7,002,764	5,026,481		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY	0	1,623,998		101.00
	SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	0	0		113.00
116.00	HOSPICE	-27,379	2,116,670		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-63,853,034	195,704,113		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	2,652,767		192.00
192.01	FASTCARE	0	495,123		192.01
193.00	NONPAID WORKERS	0	0		193.00
193.01	ADULT DAY CARE	0	0		193.01
193.02	DENMAN SERVICES	0	0		193.02
193.03	MEALS ON WHEELS	0	0		193.03
193.04	UNUSED SPACE	0	0		193.04
193.05	HEALTH EDUCATION	0	14,757		193.05
193.06	RENTED SPACE	0	0		193.06
193.07	AUGUSTA PHARMACY	0	1,007,962		193.07
200.00	TOTAL (SUM OF LINES 118-199)	-63,853,034	199,874,722		200.00

RECLASSIFICATIONS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-6 | Date/Time Prepared: 4/2/2012 1:04 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS CAFETERIA COSTS				
1.00	CAFETERIA	11.00	1,378,609	2,108,284	1.00
	TOTALS		1,378,609	2,108,284	
	B - RECLASS C-SECTION COSTS				
1.00	OPERATING ROOM	50.00	8,068	0	1.00
	TOTALS		8,068	0	
	D - RECLASS CAPITAL RELATED INSURANCE				
1.00	CAP REL COSTS-BUTLER BUILDING	1.01	0	22,229	1.00
2.00	CAP REL COSTS-OLD BUILDING & FIXT	1.02	0	42,696	2.00
3.00	CAP REL COSTS-NEW BUILDING & FIXT	1.03	0	61,671	3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,570	4.00
	TOTALS		0	132,166	
	E - RECLASS HHA THERAPY COSTS				
1.00	PHYSICAL THERAPY	66.00	227,308	44,546	1.00
2.00	OCCUPATIONAL THERAPY	67.00	57,660	11,287	2.00
3.00	SPEECH PATHOLOGY	68.00	7,127	1,408	3.00
	TOTALS		292,095	57,241	
	F - RECLASS HEALTH EDUCATION				
1.00	HEALTH EDUCATION	193.05	14,713	44	1.00
	TOTALS		14,713	44	
	G - RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-NEW BUILDING & FIXT	1.03	0	24,272	1.00
2.00	CAP REL COSTS-14TH STREET	1.04	0	1,852,601	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	613,327	3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	566,459	4.00
	TOTALS		0	3,056,659	
	H - RECLASS ER PHYSICIAN MALPRACTICE INS				
1.00	EMERGENCY	91.00	0	51,800	1.00
	TOTALS		0	51,800	
	I - RECLASS CHARGEABLE MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,049,891	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	8,965,435	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
	TOTALS		0	15,015,326	
	J - RECLASS PRECEPTOR PAY				
1.00	NURSING SCHOOL	20.00	801,285	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
	TOTALS		801,285	0	

RECLASSIFICATIONS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-6 | Date/Time Prepared: 4/2/2012 1:04 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	K - RECLASS RENT EXPENSE					
1.00	CAP REL COSTS-MOB PHASE I	1.05	0	216,519		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	216,519		
500.00	Grand Total: Increases		2,494,770	20,638,039		500.00

RECLASSIFICATIONS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-6 | Date/Time Prepared: 4/2/2012 1:04 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	1,378,609	2,108,284	0		1.00
	TOTALS		1,378,609	2,108,284			
	B - RECLASS C-SECTION COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	8,068	0	0		1.00
	TOTALS		8,068	0			
	D - RECLASS CAPITAL RELATED INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	132,166	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
4.00		0.00	0	0	12		4.00
	TOTALS		0	132,166			
	E - RECLASS HHA THERAPY COSTS						
1.00	HOME HEALTH AGENCY	101.00	292,095	57,241	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		292,095	57,241			
	F - RECLASS HEALTH EDUCATION						
1.00	NURSING ADMINISTRATION	13.00	14,713	44	0		1.00
	TOTALS		14,713	44			
	G - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	3,056,659	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	3,056,659			
	H - RECLASS ER PHYSICIAN MALPRACTICE INS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	51,800	0		1.00
	TOTALS		0	51,800			
	I - RECLASS CHARGEABLE MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	202,605	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	145,466	0		2.00
3.00	SUBPROVIDER - IPF	40.00	0	1,565	0		3.00
4.00	SUBPROVIDER - IRF	41.00	0	13,312	0		4.00
5.00	NURSERY	43.00	0	32,037	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	0	23,536	0		6.00
7.00	OPERATING ROOM	50.00	0	10,979,232	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	62,689	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	238,479	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	261,114	0		10.00
11.00	LABORATORY	60.00	0	36,312	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	98,866	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	12,185	0		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	467	0		14.00
15.00	SPEECH PATHOLOGY	68.00	0	2,543	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	2,802,952	0		16.00
17.00	ELECTROENCEPHALOGRAPHY	70.00	0	86	0		17.00
18.00	DRUGS CHARGED TO PATIENTS	73.00	0	328	0		18.00
19.00	RENAL DIALYSIS	74.00	0	405	0		19.00
20.00	RURAL HEALTH CLINIC	88.00	0	1,125	0		20.00
21.00	EMERGENCY	91.00	0	99,227	0		21.00
22.00	HOME HEALTH AGENCY	101.00	0	606	0		22.00
23.00	HOSPICE	116.00	0	189	0		23.00
	TOTALS		0	15,015,326			
	J - RECLASS PRECEPTOR PAY						
1.00	ADULTS & PEDIATRICS	30.00	400,206	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	29,526	0	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	103,841	0	0		3.00
4.00	SUBPROVIDER - IPF	40.00	31,526	0	0		4.00
5.00	NURSERY	43.00	24,792	0	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	1,133	0	0		6.00
7.00	OPERATING ROOM	50.00	90,017	0	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	11,442	0	0		8.00
9.00	ELECTROCARDIOLOGY	69.00	24,282	0	0		9.00
10.00	EMERGENCY	91.00	80,855	0	0		10.00
11.00	HOME HEALTH AGENCY	101.00	2,751	0	0		11.00
12.00	HOSPICE	116.00	914	0	0		12.00
	TOTALS		801,285	0			
	K - RECLASS RENT EXPENSE						
1.00	OPERATING ROOM	50.00	0	153,930	10		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	62,589	0		2.00
	TOTALS		0	216,519			
500.00	Grand Total: Decreases		2,494,770	20,638,039			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 4/2/2012 1:04 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	13,290,725	75,716	0	75,716	658,085	1.00
2.00	Land Improvements	5,561,554	136,217	0	136,217	0	2.00
3.00	Buildings and Fixtures	94,000,084	2,177,017	0	2,177,017	0	3.00
4.00	Building Improvements	3,564,673	0	0	0	0	4.00
5.00	Fixed Equipment	34,066,722	1,346,609	0	1,346,609	0	5.00
6.00	Movable Equipment	110,049,005	12,933,536	0	12,933,536	216,524	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	260,532,763	16,669,095	0	16,669,095	874,609	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	260,532,763	16,669,095	0	16,669,095	874,609	10.00

		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	3,951	0	0	0	0	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	247,800	0	0	0	0	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	3,303,639	0	0	0	0	1.03
1.04	CAP REL COSTS-14TH STREET	341,741	0	0	0	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	0	1.05
2.00	CAP REL COSTS-MVBLE EQUIP	10,335,935	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	14,233,066	0	0	0	0	3.00

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	307,247	0	307,247	0.001191	0	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	84,770,842	0	84,770,842	0.328670	0	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	34,467,822	0	34,467,822	0.133637	0	1.03
1.04	CAP REL COSTS-14TH STREET	15,609,194	0	15,609,194	0.060519	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0.000000	0	1.05
2.00	CAP REL COSTS-MVBLE EQUIP	122,766,018	0	122,766,018	0.475983	0	2.00
3.00	Total (sum of lines 1-2)	257,921,123	0	257,921,123	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 4/2/2012 1:04 pm

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	12,708,356	0	1.00
2.00	Land Improvements	5,697,771	0	2.00
3.00	Buildings and Fixtures	96,177,101	0	3.00
4.00	Building Improvements	3,564,673	0	4.00
5.00	Fixed Equipment	35,413,331	0	5.00
6.00	Movable Equipment	122,766,017	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	276,327,249	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	276,327,249	0	10.00

		SUMMARY OF CAPITAL		
	Cost Center Description	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	3,951	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	0	247,800	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	0	3,303,639	1.03
1.04	CAP REL COSTS-14TH STREET	0	341,741	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	1.05
2.00	CAP REL COSTS-MVBLE EQUIP	0	10,335,935	2.00
3.00	Total (sum of lines 1-2)	0	14,233,066	3.00

		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
	Cost Center Description	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	0	0	3,951	0	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	0	0	0	247,800	0	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	0	0	0	3,210,285	0	1.03
1.04	CAP REL COSTS-14TH STREET	0	0	0	338,650	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	57,337	1.05
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	10,276,740	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	14,077,426	57,337	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	22,229	0	0	26,180	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	0	42,696	0	0	290,496	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	-4,036	61,671	0	0	3,267,920	1.03
1.04	CAP REL COSTS-14TH STREET	-251,503	0	0	0	87,147	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	57,337	1.05
2.00	CAP REL COSTS-MVBLE EQUIP	-93,421	5,570	0	0	10,188,889	2.00
3.00	Total (sum of lines 1-2)	-348,960	132,166	0	0	13,917,969	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-8 | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	1.00
1.01	Investment income - CAP REL COSTS-BUTLER BUILDING (chapter 2)		0	CAP REL COSTS-BUTLER BUILDING	1.01	1.01
1.02	Investment income - CAP REL COSTS-OLD BUILDING & FIXT (chapter 2)		0	CAP REL COSTS-OLD BUILDING & FIXT	1.02	1.02
1.03	Investment income - CAP REL COSTS-NEW BUILDING & FIXT (chapter 2)		0	CAP REL COSTS-NEW BUILDING & FIXT	1.03	1.03
1.04	Investment income - CAP REL COSTS-14TH STREET (chapter 2)		0	CAP REL COSTS-14TH STREET	1.04	1.04
1.05	Investment income - CAP REL COSTS-MOB PHASE I (chapter 2)		0	CAP REL COSTS-MOB PHASE I	1.05	1.05
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)		0		0.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-496,057	ADMINISTRATIVE & GENERAL	5.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-156,294	ADMINISTRATIVE & GENERAL	5.00	7.00
8.00	Television and radio service (chapter 21)	A	-16,117	CAP REL COSTS-MVBLE EQUIP	2.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-18,584,977			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,326,197			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-1,286,267	CAFETERIA	11.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients	A	-2,444,897	DRUGS CHARGED TO PATIENTS	73.00	17.00
18.00	Sale of medical records and abstracts	B	-2,283	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)	B	-2,728,569	NURSING SCHOOL	20.00	19.00
20.00	Vending machines	B	-109,785	DIETARY	10.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	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		0	CAP REL COSTS-BLDG & FIXT	1.00	26.00
26.01	Depreciation - CAP REL COSTS-BUTLER BUILDING		0	CAP REL COSTS-BUTLER BUILDING	1.01	26.01
26.02	Depreciation - CAP REL COSTS-OLD BUILDING & FIXT		0	CAP REL COSTS-OLD BUILDING & FIXT	1.02	26.02
26.03	Depreciation - CAP REL COSTS-NEW BUILDING & FIXT		0	CAP REL COSTS-NEW BUILDING & FIXT	1.03	26.03
26.04	Depreciation - CAP REL COSTS-14TH STREET		0	CAP REL COSTS-14TH STREET	1.04	26.04
26.05	Depreciation - CAP REL COSTS-MOB PHASE I		0	CAP REL COSTS-MOB PHASE I	1.05	26.05
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	RENTAL INSURANCE EXPENSE	A	-8,946	ADMINISTRATIVE & GENERAL	5.00	33.00
33.01	DAMAGED GOODS	B	15,380	ADMINISTRATIVE & GENERAL	5.00	33.01
33.02	CHILD CARE CENTER	B	-1,542,494	EMPLOYEE BENEFITS	4.00	33.02
33.03	GUEST TRAYS	B	-5,989	DIETARY	10.00	33.03

ADJUSTMENTS TO EXPENSES | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-8 | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
33.04	BOOKKEEPING FEES	B	-128,818	ADMINISTRATIVE & GENERAL	5.00	33.04
33.05	RADIOLOGY TUITION	B	-74,150	PARAMED ED PRGM-RADIOLOGY	23.01	33.05
33.06	PRINT SHOP	B	-75,323	ADMINISTRATIVE & GENERAL	5.00	33.06
33.07	AFFILIATED ORGANIZATION FEES	B	-6,058	ADMINISTRATIVE & GENERAL	5.00	33.07
33.08	HEALTH PROMOTIONS	B	-151,731	NURSING ADMINISTRATION	13.00	33.08
33.09	HOUSEKEEPING SERVICES	B	-236,586	HOUSEKEEPING	9.00	33.09
33.10	ADVERTISING	A	-296,348	ADMINISTRATIVE & GENERAL	5.00	33.10
33.11	RENTAL PROPERTY EXPENSE	A	-147,167	CAP REL COSTS-NEW BUILDING & FIXT	1.03	33.11
33.12	REAL ESTATE TAXES ON RENTAL	A	-65,549	MAINTENANCE & REPAIRS	6.00	33.12
33.13	RENTAL PROPERTY EXPENSE	A	-37,714	MAINTENANCE & REPAIRS	6.00	33.13
33.14	DIETARY CONSULT AUTOS	A	-6,972	CAP REL COSTS-MVBLE EQUIP	2.00	33.14
33.15	INTEREST INCOME	A	-28,308	CAP REL COSTS-NEW BUILDING & FIXT	1.03	33.15
33.16	INTEREST INCOME	A	-2,104,104	CAP REL COSTS-14TH STREET	1.04	33.16
33.17	INTEREST INCOME	A	-699,776	CAP REL COSTS-MVBLE EQUIP	2.00	33.17
33.18	INTEREST INCOME	A	-660,640	ADMINISTRATIVE & GENERAL	5.00	33.18
33.19	DIETARY OUTSIDE SERVICES-SALARIES	A	-44,625	DIETARY	10.00	33.19
33.20	DIETARY OUTSIDE SERVICES-BENEFITS	A	-16,199	EMPLOYEE BENEFITS	4.00	33.20
33.21	PHYSICIAN RECRUITMENT	A	-179,330	ADMINISTRATIVE & GENERAL	5.00	33.21
33.22	NURSING SCHOOL ADVERTISING	A	-12,004	NURSING SCHOOL	20.00	33.22
33.23	LOBBYING EXPENSE	A	-34,660	ADMINISTRATIVE & GENERAL	5.00	33.23
33.24	TRANSFER TO PARENT	A	-760,359	ADMINISTRATIVE & GENERAL	5.00	33.24
33.25	HOSPICE PROFESSIONAL FEES	A	-27,379	HOSPICE	116.00	33.25
33.26	ER PHYSICIAN BENEFITS	A	-597,550	EMPLOYEE BENEFITS	4.00	33.26
33.27	ALCOHOL RELATED EXPENSES	A	-3,000	ADMINISTRATIVE & GENERAL	5.00	33.27
33.28	BOOK TO MEDICARE DEPRECIATION	A	53,813	CAP REL COSTS-NEW BUILDING & FIXT	1.03	33.28
33.29	BOOK TO MEDICARE DEPRECIATION	A	34,320	CAP REL COSTS-MVBLE EQUIP	2.00	33.29
33.30	GROUND FEES	B	-59,575	MAINTENANCE & REPAIRS	6.00	33.30
33.31	LABORATORY TUITION	B	-19,587	PARAMED ED PRGM-LABORATORY	23.02	33.31
33.32	CV SURGEON BENEFITS	A	-60,839	EMPLOYEE BENEFITS	4.00	33.32
33.33	ILLINI ER PHYSICIAN BENEFITS	A	-168,933	EMPLOYEE BENEFITS	4.00	33.33
33.34	SELF FUNDED HEALTH INSURANCE	A	-11,632,430	EMPLOYEE BENEFITS	4.00	33.34
33.35	LEASED EQUIPMENT	B	-8,421	CAP REL COSTS-MVBLE EQUIP	2.00	33.35
33.36	CHEMISTRY	B	-418	LABORATORY	60.00	33.36
33.37	STUDER GROUP EXPENSES	A	-276,176	ADMINISTRATIVE & GENERAL	5.00	33.37
33.38	TRAUMA ON-CALL	A	-450,811	ADMINISTRATIVE & GENERAL	5.00	33.38
33.39	NON-HOSPITAL DEPRECIATION	A	-68,977	CAP REL COSTS-MVBLE EQUIP	2.00	33.39
33.40	AMORTIZATION EXPENSE	A	-38,167	ADMINISTRATIVE & GENERAL	5.00	33.40
33.41	MISCELLANEOUS INCOME	B	-62,250	ADMINISTRATIVE & GENERAL	5.00	33.41
33.42	MISCELLANEOUS INCOME	B	-11,829	LABORATORY	60.00	33.42
33.43	MISCELLANEOUS INCOME	B	-3,884	ADULTS & PEDIATRICS	30.00	33.43
33.44	MISCELLANEOUS INCOME	B	-635	LABORATORY	60.00	33.44
33.45	MISCELLANEOUS INCOME	B	-260	PHYSICAL THERAPY	66.00	33.45
33.46	MISCELLANEOUS INCOME	B	-7,642	OPERATING ROOM	50.00	33.46
33.47	MISCELLANEOUS INCOME	B	-3,476	RESPIRATORY THERAPY	65.00	33.47
33.48	MISCELLANEOUS INCOME	B	-27,107	ELECTROENCEPHALOGRAPHY	70.00	33.48
33.49	MISCELLANEOUS INCOME	B	-17,780	ADMINISTRATIVE & GENERAL	5.00	33.49
33.50	MISCELLANEOUS INCOME	B	-548,947	ADMINISTRATIVE & GENERAL	5.00	33.50
33.51	MISCELLANEOUS INCOME	B	-3,091	CAP REL COSTS-14TH STREET	1.04	33.51
33.52	BPS EXPENSES	A	-11,640,123	ADMINISTRATIVE & GENERAL	5.00	33.52
33.53	ECHO OUTREACH-SALARIES	A	-11,409	ELECTROCARDIOLOGY	69.00	33.53
33.54	ECHO OUTREACH-BENEFITS	A	-4,142	EMPLOYEE BENEFITS	4.00	33.54
33.55	PHARMACY COVERAGE-SALARIES	A	-33,131	DRUGS CHARGED TO PATIENTS	73.00	33.55
33.56	PHARMACY COVERAGE-BENEFITS	A	-12,026	EMPLOYEE BENEFITS	4.00	33.56
33.57	PHARMACY COVERAGE-EXPENSES	A	-8,925	DRUGS CHARGED TO PATIENTS	73.00	33.57
33.58	PENSION ADJUSTMENT	A	-3,272,003	EMPLOYEE BENEFITS	4.00	33.58
33.59	MEDICAL RECORDS-SALARIES	A	-33,498	MEDICAL RECORDS & LIBRARY	16.00	33.59
33.60	MEDICAL RECORDS-BENEFITS	A	-12,160	EMPLOYEE BENEFITS	4.00	33.60
33.61	MEDICAL RECORDS-EXPENSES	A	-17,014	MEDICAL RECORDS & LIBRARY	16.00	33.61
33.62	PAIN MANAGEMENT-NP SALARIES	A	-47,601	OPERATING ROOM	50.00	33.62
33.63	PAIN MANAGEMENT-NP BENEFITS	A	-17,279	EMPLOYEE BENEFITS	4.00	33.63
33.64	PAIN MANAGEMENT-NP EXPENSES	A	-1,500	OPERATING ROOM	50.00	33.64
33.65	NP AND PA IN URGENT CARE SALARIES	A	-199,031	EMERGENCY	91.00	33.65
33.66	NP AND PA IN URGENT CARE BENEFITS	A	-72,248	EMPLOYEE BENEFITS	4.00	33.66
33.67			0		0.00	33.67
33.68			0		0.00	33.68
33.69			0		0.00	33.69

ADJUSTMENTS TO EXPENSES | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-8 | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
33.70			0		0.00	33.70
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-63,853,034			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-8 | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
1.01	Investment income - CAP REL COSTS-BUTLER BUILDING (chapter 2)	0	1.01
1.02	Investment income - CAP REL COSTS-OLD BUILDING & FIXT (chapter 2)	0	1.02
1.03	Investment income - CAP REL COSTS-NEW BUILDING & FIXT (chapter 2)	0	1.03
1.04	Investment income - CAP REL COSTS-14TH STREET (chapter 2)	0	1.04
1.05	Investment income - CAP REL COSTS-MOB PHASE I (chapter 2)	0	1.05
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	9	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	0	26.00
26.01	Depreciation - CAP REL COSTS-BUTLER BUILDING	0	26.01
26.02	Depreciation - CAP REL COSTS-OLD BUILDING & FIXT	0	26.02
26.03	Depreciation - CAP REL COSTS-NEW BUILDING & FIXT	0	26.03
26.04	Depreciation - CAP REL COSTS-14TH STREET	0	26.04
26.05	Depreciation - CAP REL COSTS-MOB PHASE I	0	26.05
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	RENTAL INSURANCE EXPENSE	0	33.00
33.01	DAMAGED GOODS	0	33.01
33.02	CHILD CARE CENTER	0	33.02
33.03	GUEST TRAYS	0	33.03
33.04	BOOKKEEPING FEES	0	33.04
33.05	RADIOLOGY TUITION	0	33.05
33.06	PRINT SHOP	0	33.06
33.07	AFFILIATED ORGANIZATION FEES	0	33.07
33.08	HEALTH PROMOTIONS	0	33.08
33.09	HOUSEKEEPING SERVICES	0	33.09
33.10	ADVERTISING	0	33.10

ADJUSTMENTS TO EXPENSES | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-8 | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	Wkst. A-7 Ref. 5.00		
33.11	RENTAL PROPERTY EXPENSE	9		33.11
33.12	REAL ESTATE TAXES ON RENTAL	0		33.12
33.13	RENTAL PROPERTY EXPENSE	0		33.13
33.14	DIETARY CONSULT AUTOS	11		33.14
33.15	INTEREST INCOME	11		33.15
33.16	INTEREST INCOME	11		33.16
33.17	INTEREST INCOME	11		33.17
33.18	INTEREST INCOME	0		33.18
33.19	DIETARY OUTSIDE SERVICES-SALARIES	0		33.19
33.20	DIETARY OUTSIDE SERVICES-BENEFITS	0		33.20
33.21	PHYSICIAN RECRUITMENT	0		33.21
33.22	NURSING SCHOOL ADVERTISING	0		33.22
33.23	LOBBYING EXPENSE	0		33.23
33.24	TRANSFER TO PARENT	0		33.24
33.25	HOSPICE PROFESSIONAL FEES	0		33.25
33.26	ER PHYSICIAN BENEFITS	0		33.26
33.27	ALCOHOL RELATED EXPENSES	0		33.27
33.28	BOOK TO MEDICARE DEPRECIATION	9		33.28
33.29	BOOK TO MEDICARE DEPRECIATION	9		33.29
33.30	GROUND FEES	0		33.30
33.31	LABORATORY TUITION	0		33.31
33.32	CV SURGEON BENEFITS	0		33.32
33.33	ILLINI ER PHYSICIAN BENEFITS	0		33.33
33.34	SELF FUNDED HEALTH INSURANCE	0		33.34
33.35	LEASED EQUIPMENT	9		33.35
33.36	CHEMISTRY	0		33.36
33.37	STUDER GROUP EXPENSES	0		33.37
33.38	TRAUMA ON-CALL	0		33.38
33.39	NON-HOSPITAL DEPRECIATION	9		33.39
33.40	AMORTIZATION EXPENSE	0		33.40
33.41	MISCELLANEOUS INCOME	0		33.41
33.42	MISCELLANEOUS INCOME	0		33.42
33.43	MISCELLANEOUS INCOME	0		33.43
33.44	MISCELLANEOUS INCOME	0		33.44
33.45	MISCELLANEOUS INCOME	0		33.45
33.46	MISCELLANEOUS INCOME	0		33.46
33.47	MISCELLANEOUS INCOME	0		33.47
33.48	MISCELLANEOUS INCOME	0		33.48
33.49	MISCELLANEOUS INCOME	0		33.49
33.50	MISCELLANEOUS INCOME	0		33.50
33.51	MISCELLANEOUS INCOME	9		33.51
33.52	BPS EXPENSES	0		33.52
33.53	ECHO OUTREACH-SALARIES	0		33.53
33.54	ECHO OUTREACH-BENEFITS	0		33.54
33.55	PHARMACY COVERAGE-SALARIES	0		33.55
33.56	PHARMACY COVERAGE-BENEFITS	0		33.56
33.57	PHARMACY COVERAGE-EXPENSES	0		33.57
33.58	PENSION ADJUSTMENT	0		33.58
33.59	MEDICAL RECORDS-SALARIES	0		33.59
33.60	MEDICAL RECORDS-BENEFITS	0		33.60
33.61	MEDICAL RECORDS-EXPENSES	0		33.61
33.62	PAIN MANAGEMENT-NP SALARIES	0		33.62
33.63	PAIN MANAGEMENT-NP BENEFITS	0		33.63
33.64	PAIN MANAGEMENT-NP EXPENSES	0		33.64
33.65	NP AND PA IN URGENT CARE SALARIES	0		33.65
33.66	NP AND PA IN URGENT CARE BENEFITS	0		33.66
33.67		0		33.67
33.68		0		33.68
33.69		0		33.69
33.70		0		33.70
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 140015	Period: From 10/01/2010 To 09/30/2011	Worksheet A-8-1 Date/Time Prepared: 4/2/2012 1:04 pm

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00		6.00	MAINTENANCE & REPAIRS	BIO-MED	1.00
2.00		8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	2.00
3.00		88.00	RURAL HEALTH CLINIC	EAST ADAMS RENT	3.00
4.00		5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	4.00
4.01		4.00	EMPLOYEE BENEFITS	BCS BENEFITS	4.01
4.02		1.05	CAP REL COSTS-MOB PHASE I	SURGERY RENT	4.02
4.03		1.05	CAP REL COSTS-MOB PHASE I	RADIOLOGY RENT	4.03
4.04		1.05	CAP REL COSTS-MOB PHASE I	WOUND RENT	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-8-1 | Date/Time Prepared: 4/2/2012 1:04 pm

		Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
		4.00	5.00	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		563,236	870,400	-307,164	0		1.00
2.00		989,184	929,597	59,587	0		2.00
3.00		51,264	69,254	-17,990	8		3.00
4.00		6,065,771	6,555,983	-490,212	0		4.00
4.01		-411,236	0	-411,236	0		4.01
4.02		17,979	67,894	-49,915	10		4.02
4.03		16,574	62,589	-46,015	10		4.03
4.04		22,784	86,036	-63,252	10		4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	7,315,556	8,641,753	-1,326,197			5.00

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

		Related Organization(s) and/or Home Office			
		Name	Percentage of Ownership	Type of Business	
		4.00	5.00	6.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				
6.00		DENMAN SERVICES	0.00	BIO-MED MAINT	6.00
7.00		DENMAN SERVICES	0.00	LAUNDRY SVCS	7.00
8.00		BLESS FOUND	0.00	FUND RAISING	8.00
9.00		BLESS CORP SVCS	0.00	HOME OFFICE	9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 4/2/2012 1:04 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		5.00	A&G	1,490,855	1,356,505	1.00
2.00		5.00	A&G	294,376	0	2.00
3.00		5.00	A&G	1,689,629	1,689,629	3.00
4.00		4.00	EMPLOYEE BENEFITS	4,761	4,761	4.00
5.00		30.00	CANCER CENTER	31,526	0	5.00
6.00		31.00	ICU	36,000	0	6.00
7.00		41.00	REHAB	33,000	0	7.00
8.00		44.00	SNU	1,375	0	8.00
9.00		60.00	LABORATORY	61,504	61,504	9.00
10.00		65.00	PULMONARY	10,800	0	10.00
11.00		65.00	RESPIRATORY THERAPY	10,800	0	11.00
12.00		70.00	SLEEP STUDIES	15,000	0	12.00
13.00		69.00	EKG	14,040	0	13.00
14.00		69.00	CARDIAC CATH	16,220	770	14.00
15.00		70.00	EEG	1,875	0	15.00
16.00		91.00	EMS	31,200	0	16.00
17.00		91.00	ER TRAUMA	73,000	5,000	17.00
18.00		91.00	SALARIED ER PHYSICIANS	5,363,537	5,363,537	18.00
19.00		91.00	ER DIRECTORS	187,440	0	19.00
20.00		91.00	ILLINI ER PHYSICIANS	977,543	977,543	20.00
21.00		91.00	ILLINI ER PHYSICIANS	351,019	351,019	21.00
22.00		50.00	SURGERY CENTER	120,216	0	22.00
23.00		5.00	ANESTHESIA	7,599,861	7,599,861	23.00
24.00		50.00	CV SURGEON	170,835	170,835	24.00
25.00		50.00	CV SURGEON	576,652	576,652	25.00
200.00			TOTAL (lines 1.00 through 199.00)	19,163,064	18,157,616	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 4/2/2012 1:04 pm

		Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
		5.00	6.00	7.00	8.00	9.00	
1.00		134,350	159,800	941	72,294	3,615	1.00
2.00		294,376	208,000	1,840	184,000	9,200	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00		31,526	159,800	226	17,363	868	5.00
6.00		36,000	159,800	288	22,126	1,106	6.00
7.00		33,000	159,800	264	20,282	1,014	7.00
8.00		1,375	159,800	11	845	42	8.00
9.00		0	0	0	0	0	9.00
10.00		10,800	159,800	72	5,531	277	10.00
11.00		10,800	159,800	72	5,531	277	11.00
12.00		15,000	159,800	120	9,219	461	12.00
13.00		14,040	159,800	108	8,297	415	13.00
14.00		15,450	182,900	103	9,057	453	14.00
15.00		1,875	159,800	15	1,152	58	15.00
16.00		31,200	159,800	240	18,439	922	16.00
17.00		68,000	159,800	336	25,814	1,291	17.00
18.00		0	0	0	0	0	18.00
19.00		187,440	159,800	1,767	135,753	6,788	19.00
20.00		0	0	0	0	0	20.00
21.00		0	0	0	0	0	21.00
22.00		120,216	182,900	482	42,384	2,119	22.00
23.00		0	0	0	0	0	23.00
24.00		0	0	0	0	0	24.00
25.00		0	0	0	0	0	25.00
200.00		1,005,448		6,885	578,087	28,906	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 4/2/2012 1:04 pm

		Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	
		12.00	13.00	14.00	15.00	16.00	
1.00		0	0	0	0	72,294	1.00
2.00		0	0	0	0	184,000	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00		0	0	0	0	17,363	5.00
6.00		0	0	0	0	22,126	6.00
7.00		0	0	0	0	20,282	7.00
8.00		0	0	0	0	845	8.00
9.00		0	0	0	0	0	9.00
10.00		0	0	0	0	5,531	10.00
11.00		0	0	0	0	5,531	11.00
12.00		0	0	0	0	9,219	12.00
13.00		0	0	0	0	8,297	13.00
14.00		0	0	0	0	9,057	14.00
15.00		0	0	0	0	1,152	15.00
16.00		0	0	0	0	18,439	16.00
17.00		0	0	0	0	25,814	17.00
18.00		0	0	0	0	0	18.00
19.00		0	0	0	0	135,753	19.00
20.00		0	0	0	0	0	20.00
21.00		0	0	0	0	0	21.00
22.00		0	0	0	0	42,384	22.00
23.00		0	0	0	0	0	23.00
24.00		0	0	0	0	0	24.00
25.00		0	0	0	0	0	25.00
200.00		0	0	0	0	578,087	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 4/2/2012 1:04 pm

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		62,056	1,418,561		1.00
2.00		110,376	110,376		2.00
3.00		0	1,689,629		3.00
4.00		0	4,761		4.00
5.00		14,163	14,163		5.00
6.00		13,874	13,874		6.00
7.00		12,718	12,718		7.00
8.00		530	530		8.00
9.00		0	61,504		9.00
10.00		5,269	5,269		10.00
11.00		5,269	5,269		11.00
12.00		5,781	5,781		12.00
13.00		5,743	5,743		13.00
14.00		6,393	7,163		14.00
15.00		723	723		15.00
16.00		12,761	12,761		16.00
17.00		42,186	47,186		17.00
18.00		0	5,363,537		18.00
19.00		51,687	51,687		19.00
20.00		0	977,543		20.00
21.00		0	351,019		21.00
22.00		77,832	77,832		22.00
23.00		0	7,599,861		23.00
24.00		0	170,835		24.00
25.00		0	576,652		25.00
200.00		427,361	18,584,977		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part I Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
			BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT	
		0	1.00	1.01	1.02	1.03	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01	CAP REL COSTS-BUTLER BUILDING	26,180	0	26,180			1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	290,496	0	0	290,496		1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	3,267,920	0	0	0	3,267,920	1.03
1.04	CAP REL COSTS-14TH STREET	87,147	0	0	0	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	57,337	0	0	0	0	1.05
2.00	CAP REL COSTS-MVBLE EQUIP	10,188,889					2.00
4.00	EMPLOYEE BENEFITS	21,758,627	0	0	12,838	171,478	4.00
5.00	ADMINISTRATIVE & GENERAL	32,888,105	0	0	77,399	605,898	5.00
6.00	MAINTENANCE & REPAIRS	5,960,852	0	5,514	36,781	396,129	6.00
8.00	LAUNDRY & LINEN SERVICE	1,071,551	0	0	3,953	0	8.00
9.00	HOUSEKEEPING	2,235,492	0	0	8,091	2,687	9.00
10.00	DIETARY	1,866,454	0	0	0	82,548	10.00
11.00	CAFETERIA	2,200,626	0	0	0	25,060	11.00
13.00	NURSING ADMINISTRATION	5,381,740	0	0	6,933	2,651	13.00
16.00	MEDICAL RECORDS & LIBRARY	2,464,064	0	0	1,104	51,661	16.00
20.00	NURSING SCHOOL	1,535,515	0	20,666	0	151,595	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	1,012,486	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,219,351	0	0	0	0	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
23.01	PARAMED ED PRGM-RADIOLOGY	163,595	0	0	0	3,768	23.01
23.02	PARAMED ED PRGM-LABORATORY	57,596	0	0	1,147	0	23.02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	14,835,347	0	0	12,055	614,996	30.00
31.00	INTENSIVE CARE UNIT	4,022,598	0	0	23,300	90,193	31.00
40.00	SUBPROVIDER - IPF	3,309,979	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	1,602,297	0	0	1,936	33,224	41.00
43.00	NURSERY	466,668	0	0	0	20,197	43.00
44.00	SKILLED NURSING FACILITY	1,525,412	0	0	0	66,382	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	11,589,080	0	0	23,460	186,710	50.00
52.00	DELIVERY ROOM & LABOR ROOM	1,289,579	0	0	10,255	0	52.00
53.00	ANESTHESIOLOGY	330,699	0	0	1,396	4,951	53.00
54.00	RADIOLOGY-DIAGNOSTIC	7,674,154	0	0	0	242,854	54.00
60.00	LABORATORY	5,487,579	0	0	224	88,842	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,433,474	0	0	856	0	62.00
65.00	RESPIRATORY THERAPY	2,130,939	0	0	14,517	0	65.00
66.00	PHYSICAL THERAPY	2,497,358	0	0	4,718	46,017	66.00
67.00	OCCUPATIONAL THERAPY	734,247	0	0	3,649	0	67.00
68.00	SPEECH PATHOLOGY	256,061	0	0	1,236	0	68.00
69.00	ELECTROCARDIOLOGY	2,405,806	0	0	13,884	28,777	69.00
70.00	ELECTROENCEPHALOGRAPHY	338,053	0	0	4,858	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,260,030	0	0	0	28,105	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	8,965,435	0	0	0	41,650	72.00
73.00	DRUGS CHARGED TO PATIENTS	13,631,837	0	0	716	29,398	73.00
74.00	RENAL DIALYSIS	676,437	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	739,872	0	0	0	0	88.00
91.00	EMERGENCY	5,026,481	0	0	15,984	128,280	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	1,623,998	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	2,116,670	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	195,704,113	0	26,180	281,290	3,144,051	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	5,655	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	2,652,767	0	0	0	0	192.00
192.01	FASTCARE	495,123	0	0	0	0	192.01
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	ADULT DAY CARE	0	0	0	0	0	193.01
193.02	DENMAN SERVICES	0	0	0	0	7,302	193.02
193.03	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	UNUSED SPACE	0	0	0	2,609	1,628	193.04
193.05	HEALTH EDUCATION	14,757	0	0	0	0	193.05
193.06	RENTED SPACE	0	0	0	942	114,939	193.06
193.07	AUGUSTA PHARMACY	1,007,962	0	0	0	0	193.07

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part I Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
			BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT	
		0	1.00	1.01	1.02	1.03	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	199,874,722	0	26,180	290,496	3,267,920	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part I | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	Subtotal	
		14TH STREET	MOB PHASE I	MVBLE EQUIP			
		1.04	1.05	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT						1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT						1.03
1.04	CAP REL COSTS-14TH STREET	87,147					1.04
1.05	CAP REL COSTS-MOB PHASE I	0	57,337				1.05
2.00	CAP REL COSTS-MVBLE EQUIP			10,188,889			2.00
4.00	EMPLOYEE BENEFITS	216	0	178,048	22,121,207		4.00
5.00	ADMINISTRATIVE & GENERAL	20,564	0	3,802,138	2,862,013	40,256,117	5.00
6.00	MAINTENANCE & REPAIRS	19,283	0	144,199	587,920	7,150,678	6.00
8.00	LAUNDRY & LINEN SERVICE	127	0	6,633	14,966	1,097,230	8.00
9.00	HOUSEKEEPING	869	0	103,473	509,012	2,859,624	9.00
10.00	DIETARY	1,306	0	16,726	185,597	2,152,631	10.00
11.00	CAFETERIA	1,725	0	0	338,120	2,565,531	11.00
13.00	NURSING ADMINISTRATION	1,172	0	755,354	1,172,915	7,320,765	13.00
16.00	MEDICAL RECORDS & LIBRARY	382	0	95,043	401,473	3,013,727	16.00
20.00	NURSING SCHOOL	1,177	0	84,778	778,205	2,571,936	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	248,324	1,260,810	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	18	0	1,219,369	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
23.01	PARAMED ED PRGM-RADIOLOGY	0	0	0	56,454	223,817	23.01
23.02	PARAMED ED PRGM-LABORATORY	0	0	0	18,319	77,062	23.02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	0	216,996	3,420,910	19,100,304	30.00
31.00	INTENSIVE CARE UNIT	0	0	253,989	911,102	5,301,182	31.00
40.00	SUBPROVIDER - IPF	8,531	0	6,853	792,890	4,118,253	40.00
41.00	SUBPROVIDER - IRF	0	0	26,485	339,448	2,003,390	41.00
43.00	NURSERY	0	0	5,835	103,468	596,168	43.00
44.00	SKILLED NURSING FACILITY	0	0	3,107	349,351	1,944,252	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	40,763	1,569,800	1,715,882	15,125,695	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	45,053	277,921	1,622,808	52.00
53.00	ANESTHESIOLOGY	0	0	78,442	39,208	454,696	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	16,574	1,385,449	1,139,559	10,458,590	54.00
60.00	LABORATORY	113	0	223,185	746,540	6,546,483	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	51,309	1,485,639	62.00
65.00	RESPIRATORY THERAPY	0	0	0	465,199	2,610,655	65.00
66.00	PHYSICAL THERAPY	0	0	8,161	543,711	3,099,965	66.00
67.00	OCCUPATIONAL THERAPY	0	0	1,997	175,119	915,012	67.00
68.00	SPEECH PATHOLOGY	0	0	0	61,584	318,881	68.00
69.00	ELECTROCARDIOLOGY	0	0	682,377	345,437	3,476,281	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	11,556	69,695	424,162	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,828	0	30,263	66,249	7,386,475	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	2,708	0	44,848	98,176	9,152,817	72.00
73.00	DRUGS CHARGED TO PATIENTS	110	0	150,316	724,369	14,536,746	73.00
74.00	RENAL DIALYSIS	0	0	0	0	676,437	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	86,438	826,310	88.00
91.00	EMERGENCY	2,831	0	205,504	960,266	6,339,346	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	1,660	0	15,100	311,785	1,952,543	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	2,609	0	23,336	378,655	2,521,270	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	67,211	57,337	10,175,062	21,347,589	194,763,657	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,059	0	0	0	6,714	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	7,299	0	8,286	633,778	3,302,130	192.00
192.01	FASTCARE	0	0	4,786	96,776	596,685	192.01
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	ADULT DAY CARE	0	0	0	0	0	193.01
193.02	DENMAN SERVICES	718	0	285	0	8,305	193.02
193.03	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	UNUSED SPACE	7,455	0	0	0	11,692	193.04
193.05	HEALTH EDUCATION	0	0	0	3,609	18,366	193.05
193.06	RENTED SPACE	3,405	0	0	0	119,286	193.06
193.07	AUGUSTA PHARMACY	0	0	470	39,455	1,047,887	193.07
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	87,147	57,337	10,188,889	22,121,207	199,874,722	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part I | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT						1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT						1.03
1.04	CAP REL COSTS-14TH STREET						1.04
1.05	CAP REL COSTS-MOB PHASE I						1.05
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	40,256,117					5.00
6.00	MAINTENANCE & REPAIRS	1,803,415	8,954,093				6.00
8.00	LAUNDRY & LINEN SERVICE	276,724	36,677	1,410,631			8.00
9.00	HOUSEKEEPING	721,203	112,108	0	3,692,935		9.00
10.00	DIETARY	542,898	258,375	6,905	58,245	3,019,054	10.00
11.00	CAFETERIA	647,032	145,535	0	100,224	0	11.00
13.00	NURSING ADMINISTRATION	1,846,312	118,491	0	51,912	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	760,068	148,156	0	38,588	0	16.00
20.00	NURSING SCHOOL	648,647	656,515	0	97,352	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	317,979	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	307,527	0	0	0	0	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
23.01	PARAMED ED PRGM-RADIOLOGY	56,447	8,782	0	450	0	23.01
23.02	PARAMED ED PRGM-LABORATORY	19,435	8,782	0	0	0	23.02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,817,121	1,525,791	613,230	891,634	1,800,694	30.00
31.00	INTENSIVE CARE UNIT	1,336,969	388,677	77,212	260,147	265,044	31.00
40.00	SUBPROVIDER - IPF	1,038,632	430,852	33,765	233,880	443,794	40.00
41.00	SUBPROVIDER - IRF	505,259	92,263	37,216	107,181	230,018	41.00
43.00	NURSERY	150,355	47,076	5,727	23,914	0	43.00
44.00	SKILLED NURSING FACILITY	490,344	154,725	47,935	82,021	279,504	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	3,814,731	756,097	184,935	478,592	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	409,275	78,546	26,093	94,826	0	52.00
53.00	ANESTHESIOLOGY	114,675	22,228	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,637,677	623,480	105,932	198,926	0	54.00
60.00	LABORATORY	1,651,036	214,515	1,606	66,136	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	374,681	6,553	0	1,038	0	62.00
65.00	RESPIRATORY THERAPY	658,412	111,189	636	71,223	0	65.00
66.00	PHYSICAL THERAPY	781,817	143,390	19,924	60,495	0	66.00
67.00	OCCUPATIONAL THERAPY	230,768	27,946	0	0	0	67.00
68.00	SPEECH PATHOLOGY	80,422	9,463	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	876,725	173,413	29,085	27,133	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	106,975	37,205	11,394	12,978	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,862,884	157,806	9,109	25,817	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	2,308,359	233,867	13,499	38,761	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,666,196	79,567	0	31,528	0	73.00
74.00	RENAL DIALYSIS	170,599	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	208,397	0	0	623	0	88.00
91.00	EMERGENCY	1,598,796	564,388	179,713	317,492	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	492,435	83,822	0	179,096	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	635,869	131,783	1,668	22,426	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	38,967,096	7,588,063	1,405,584	3,572,638	3,019,054	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,693	96,774	5,047	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	832,804	368,611	0	0	0	192.00
192.01	FASTCARE	150,485	0	0	0	0	192.01
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	ADULT DAY CARE	0	0	0	0	0	193.01
193.02	DENMAN SERVICES	2,095	53,288	0	21,595	0	193.02
193.03	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	UNUSED SPACE	2,949	400,285	0	0	0	193.04
193.05	HEALTH EDUCATION	4,632	0	0	0	0	193.05
193.06	RENTED SPACE	30,084	447,072	0	98,702	0	193.06
193.07	AUGUSTA PHARMACY	264,279	0	0	0	0	193.07
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)	40,256,117	8,954,093	1,410,631	3,692,935	3,019,054	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part I | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL		
		11.00	13.00	16.00	20.00		
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT						1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT						1.03
1.04	CAP REL COSTS-14TH STREET						1.04
1.05	CAP REL COSTS-MOB PHASE I						1.05
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	3,458,322					11.00
13.00	NURSING ADMINISTRATION	226,038	9,563,518				13.00
16.00	MEDICAL RECORDS & LIBRARY	128,058	0	4,088,597			16.00
20.00	NURSING SCHOOL	147,893	0	0	4,122,343		20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	47,470	0	0	0		22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0		23.00
23.01	PARAMED ED PRGM-RADIOLOGY	10,567	0	0	0		23.01
23.02	PARAMED ED PRGM-LABORATORY	2,622	0	0	0		23.02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	731,296	3,503,051	2,416,687	2,909,241		30.00
31.00	INTENSIVE CARE UNIT	165,900	794,670	355,732	339,933		31.00
40.00	SUBPROVIDER - IPF	171,743	822,675	595,625	254,803		40.00
41.00	SUBPROVIDER - IRF	71,046	340,329	308,727	20,842		41.00
43.00	NURSERY	17,076	81,781	10,991	54,160		43.00
44.00	SKILLED NURSING FACILITY	79,708	381,810	375,127	0		44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	349,645	1,674,842	0	163,068		50.00
52.00	DELIVERY ROOM & LABOR ROOM	50,314	241,002	0	158,224		52.00
53.00	ANESTHESIOLOGY	11,934	57,166	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	209,953	0	0	0		54.00
60.00	LABORATORY	177,056	0	0	0		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	9,559	0	0	0		62.00
65.00	RESPIRATORY THERAPY	93,008	0	0	0		65.00
66.00	PHYSICAL THERAPY	89,549	0	0	0		66.00
67.00	OCCUPATIONAL THERAPY	26,660	0	0	0		67.00
68.00	SPEECH PATHOLOGY	11,037	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	62,009	0	0	5,871		69.00
70.00	ELECTROENCEPHALOGRAPHY	17,238	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,765	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	35,211	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	115,389	0	0	0		73.00
74.00	RENAL DIALYSIS	0	0	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0		88.00
91.00	EMERGENCY	192,765	923,382	25,708	210,330		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	61,248	293,404	0	0		101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0		113.00
116.00	HOSPICE	78,316	375,134	0	5,871		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,414,073	9,489,246	4,088,597	4,122,343		118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	43,497	0	0	0		192.00
192.01	FASTCARE	0	74,272	0	0		192.01
193.00	NONPAID WORKERS	0	0	0	0		193.00
193.01	ADULT DAY CARE	0	0	0	0		193.01
193.02	DENMAN SERVICES	0	0	0	0		193.02
193.03	MEALS ON WHEELS	0	0	0	0		193.03
193.04	UNUSED SPACE	0	0	0	0		193.04
193.05	HEALTH EDUCATION	752	0	0	0		193.05
193.06	RENTED SPACE	0	0	0	0		193.06
193.07	AUGUSTA PHARMACY	0	0	0	0		193.07
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	3,458,322	9,563,518	4,088,597	4,122,343		202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part I Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
		21.00	22.00	23.00	23.01	23.02	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT						1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT						1.03
1.04	CAP REL COSTS-14TH STREET						1.04
1.05	CAP REL COSTS-MOB PHASE I						1.05
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION						13.00
16.00	MEDICAL RECORDS & LIBRARY						16.00
20.00	NURSING SCHOOL						20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	1,578,789					21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,574,366				22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
23.01	PARAMED ED PRGM-RADIOLOGY	0	0	0	300,063		23.01
23.02	PARAMED ED PRGM-LABORATORY	0	0	0	0	107,901	23.02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,103,883	1,100,791	0	0	0	30.00
31.00	INTENSIVE CARE UNIT	47,594	47,461	0	0	0	31.00
40.00	SUBPROVIDER - IPF	40,289	40,176	0	0	0	40.00
41.00	SUBPROVIDER - IRF	56,153	55,996	0	0	0	41.00
43.00	NURSERY	29,294	29,212	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	100,132	99,851	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	3,689	3,679	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	15,865	15,820	0	300,063	0	54.00
60.00	LABORATORY	15,865	15,820	0	0	107,901	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	56,153	55,996	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	8,560	8,536	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	EMERGENCY	101,312	101,028	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,578,789	1,574,366	0	300,063	107,901	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	FASTCARE	0	0	0	0	0	192.01
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	ADULT DAY CARE	0	0	0	0	0	193.01
193.02	DENMAN SERVICES	0	0	0	0	0	193.02
193.03	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	UNUSED SPACE	0	0	0	0	0	193.04
193.05	HEALTH EDUCATION	0	0	0	0	0	193.05
193.06	RENTED SPACE	0	0	0	0	0	193.06
193.07	AUGUSTA PHARMACY	0	0	0	0	0	193.07
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part I Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
		21.00	22.00	23.00	23.01	23.02	
202.00	TOTAL (sum lines 118-201)	1,578,789	1,574,366	0	300,063	107,901	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part I | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
1.01	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT					1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT					1.03
1.04	CAP REL COSTS-14TH STREET					1.04
1.05	CAP REL COSTS-MOB PHASE I					1.05
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
6.00	MAINTENANCE & REPAIRS					6.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
20.00	NURSING SCHOOL					20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23.00	PARAMED ED PRGM-(SPECIFY)					23.00
23.01	PARAMED ED PRGM-RADIOLOGY					23.01
23.02	PARAMED ED PRGM-LABORATORY					23.02
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	40,513,723	-2,204,674	38,309,049		30.00
31.00	INTENSIVE CARE UNIT	9,380,521	-95,055	9,285,466		31.00
40.00	SUBPROVIDER - IPF	8,224,487	-80,465	8,144,022		40.00
41.00	SUBPROVIDER - IRF	3,828,420	-112,149	3,716,271		41.00
43.00	NURSERY	1,045,754	-58,506	987,248		43.00
44.00	SKILLED NURSING FACILITY	3,835,426	0	3,835,426		44.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	22,747,588	-199,983	22,547,605		50.00
52.00	DELIVERY ROOM & LABOR ROOM	2,681,088	0	2,681,088		52.00
53.00	ANESTHESIOLOGY	668,067	-7,368	660,699		53.00
54.00	RADIOLOGY-DIAGNOSTIC	14,566,306	-31,685	14,534,621		54.00
60.00	LABORATORY	8,796,418	-31,685	8,764,733		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,877,470	0	1,877,470		62.00
65.00	RESPIRATORY THERAPY	3,545,123	0	3,545,123		65.00
66.00	PHYSICAL THERAPY	4,195,140	0	4,195,140		66.00
67.00	OCCUPATIONAL THERAPY	1,200,386	0	1,200,386		67.00
68.00	SPEECH PATHOLOGY	419,803	0	419,803		68.00
69.00	ELECTROCARDIOLOGY	4,762,666	-112,149	4,650,517		69.00
70.00	ELECTROENCEPHALOGRAPHY	627,048	-17,096	609,952		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,465,856	0	9,465,856		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	11,782,514	0	11,782,514		72.00
73.00	DRUGS CHARGED TO PATIENTS	18,429,426	0	18,429,426		73.00
74.00	RENAL DIALYSIS	847,036	0	847,036		74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	1,035,330	0	1,035,330		88.00
91.00	EMERGENCY	10,554,260	-202,340	10,351,920		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
	OTHER REIMBURSABLE COST CENTERS					
101.00	HOME HEALTH AGENCY	3,062,548	0	3,062,548		101.00
	SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE	0	0	0		113.00
116.00	HOSPICE	3,772,337	0	3,772,337		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	191,864,741	-3,153,155	188,711,586		118.00
	NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	110,228	0	110,228		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	4,547,042	0	4,547,042		192.00
192.01	FASTCARE	821,442	0	821,442		192.01
193.00	NONPAID WORKERS	0	0	0		193.00
193.01	ADULT DAY CARE	0	0	0		193.01
193.02	DENMAN SERVICES	85,283	0	85,283		193.02
193.03	MEALS ON WHEELS	0	0	0		193.03
193.04	UNUSED SPACE	414,926	0	414,926		193.04
193.05	HEALTH EDUCATION	23,750	0	23,750		193.05
193.06	RENTED SPACE	695,144	0	695,144		193.06
193.07	AUGUSTA PHARMACY	1,312,166	0	1,312,166		193.07
200.00	Cross Foot Adjustments	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0		201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part I Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
202.00	TOTAL (sum lines 118-201)	199,874,722	-3,153,155	196,721,567		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part II | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT	
		0	1.00	1.01	1.02	1.03	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT						1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT						1.03
1.04	CAP REL COSTS-14TH STREET						1.04
1.05	CAP REL COSTS-MOB PHASE I						1.05
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	0	0	0	12,838	171,478	4.00
5.00	ADMINISTRATIVE & GENERAL	0	0	0	77,399	605,898	5.00
6.00	MAINTENANCE & REPAIRS	0	0	5,514	36,781	396,129	6.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	3,953	0	8.00
9.00	HOUSEKEEPING	0	0	0	8,091	2,687	9.00
10.00	DIETARY	0	0	0	0	82,548	10.00
11.00	CAFETERIA	0	0	0	0	25,060	11.00
13.00	NURSING ADMINISTRATION	0	0	0	6,933	2,651	13.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	1,104	51,661	16.00
20.00	NURSING SCHOOL	0	0	20,666	0	151,595	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
23.01	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	3,768	23.01
23.02	PARAMED ED PRGM-LABORATORY	0	0	0	1,147	0	23.02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	0	0	12,055	614,996	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	23,300	90,193	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	1,936	33,224	41.00
43.00	NURSERY	0	0	0	0	20,197	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	66,382	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	23,460	186,710	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	10,255	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	1,396	4,951	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	242,854	54.00
60.00	LABORATORY	0	0	0	224	88,842	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	856	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	14,517	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	4,718	46,017	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	3,649	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	1,236	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	13,884	28,777	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	4,858	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	28,105	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	41,650	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	716	29,398	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	EMERGENCY	0	0	0	15,984	128,280	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	26,180	281,290	3,144,051	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	5,655	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	FASTCARE	0	0	0	0	0	192.01
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	ADULT DAY CARE	0	0	0	0	0	193.01
193.02	DENMAN SERVICES	0	0	0	0	7,302	193.02
193.03	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	UNUSED SPACE	0	0	0	2,609	1,628	193.04
193.05	HEALTH EDUCATION	0	0	0	0	0	193.05
193.06	RENTED SPACE	0	0	0	942	114,939	193.06
193.07	AUGUSTA PHARMACY	0	0	0	0	0	193.07
200.00	Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part II Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT	
		0	1.00	1.01	1.02	1.03	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	0	26,180	290,496	3,267,920	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part II Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	CAPITAL RELATED COSTS			Subtotal	EMPLOYEE BENEFITS	
		14TH STREET	MOB PHASE I	MVBLE EQUIP			
		1.04	1.05	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT						1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT						1.03
1.04	CAP REL COSTS-14TH STREET						1.04
1.05	CAP REL COSTS-MOB PHASE I						1.05
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	216	0	178,048	362,580	362,580	4.00
5.00	ADMINISTRATIVE & GENERAL	20,564	0	3,802,138	4,505,999	46,910	5.00
6.00	MAINTENANCE & REPAIRS	19,283	0	144,199	601,906	9,636	6.00
8.00	LAUNDRY & LINEN SERVICE	127	0	6,633	10,713	245	8.00
9.00	HOUSEKEEPING	869	0	103,473	115,120	8,343	9.00
10.00	DIETARY	1,306	0	16,726	100,580	3,042	10.00
11.00	CAFETERIA	1,725	0	0	26,785	5,542	11.00
13.00	NURSING ADMINISTRATION	1,172	0	755,354	766,110	19,225	13.00
16.00	MEDICAL RECORDS & LIBRARY	382	0	95,043	148,190	6,580	16.00
20.00	NURSING SCHOOL	1,177	0	84,778	258,216	12,755	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	4,070	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	18	18	0	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
23.01	PARAMED ED PRGM-RADIOLOGY	0	0	0	3,768	925	23.01
23.02	PARAMED ED PRGM-LABORATORY	0	0	0	1,147	300	23.02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	0	216,996	844,047	56,074	30.00
31.00	INTENSIVE CARE UNIT	0	0	253,989	367,482	14,934	31.00
40.00	SUBPROVIDER - IPF	8,531	0	6,853	15,384	12,996	40.00
41.00	SUBPROVIDER - IRF	0	0	26,485	61,645	5,564	41.00
43.00	NURSERY	0	0	5,835	26,032	1,696	43.00
44.00	SKILLED NURSING FACILITY	0	0	3,107	69,489	5,726	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	40,763	1,569,800	1,820,733	28,124	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	45,053	55,308	4,555	52.00
53.00	ANESTHESIOLOGY	0	0	78,442	84,789	643	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	16,574	1,385,449	1,644,877	18,678	54.00
60.00	LABORATORY	113	0	223,185	312,364	12,236	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	856	841	62.00
65.00	RESPIRATORY THERAPY	0	0	0	14,517	7,625	65.00
66.00	PHYSICAL THERAPY	0	0	8,161	58,896	8,912	66.00
67.00	OCCUPATIONAL THERAPY	0	0	1,997	5,646	2,870	67.00
68.00	SPEECH PATHOLOGY	0	0	0	1,236	1,009	68.00
69.00	ELECTROCARDIOLOGY	0	0	682,377	725,038	5,662	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	11,556	16,414	1,142	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,828	0	30,263	60,196	1,086	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	2,708	0	44,848	89,206	1,609	72.00
73.00	DRUGS CHARGED TO PATIENTS	110	0	150,316	180,540	11,873	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	1,417	88.00
91.00	EMERGENCY	2,831	0	205,504	352,599	15,739	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	1,660	0	15,100	16,760	5,110	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	2,609	0	23,336	25,945	6,206	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	67,211	57,337	10,175,062	13,751,131	349,900	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,059	0	0	6,714	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	7,299	0	8,286	15,585	10,388	192.00
192.01	FASTCARE	0	0	4,786	4,786	1,586	192.01
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	ADULT DAY CARE	0	0	0	0	0	193.01
193.02	DENMAN SERVICES	718	0	285	8,305	0	193.02
193.03	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	UNUSED SPACE	7,455	0	0	11,692	0	193.04
193.05	HEALTH EDUCATION	0	0	0	0	59	193.05
193.06	RENTED SPACE	3,405	0	0	119,286	0	193.06
193.07	AUGUSTA PHARMACY	0	0	470	470	647	193.07
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	87,147	57,337	10,188,889	13,917,969	362,580	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part II | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT						1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT						1.03
1.04	CAP REL COSTS-14TH STREET						1.04
1.05	CAP REL COSTS-MOB PHASE I						1.05
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	4,552,909					5.00
6.00	MAINTENANCE & REPAIRS	203,966	815,508				6.00
8.00	LAUNDRY & LINEN SERVICE	31,297	3,340	45,595			8.00
9.00	HOUSEKEEPING	81,568	10,210	0	215,241		9.00
10.00	DIETARY	61,402	23,532	223	3,395	192,174	10.00
11.00	CAFETERIA	73,179	13,255	0	5,842	0	11.00
13.00	NURSING ADMINISTRATION	208,818	10,792	0	3,026	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	85,964	13,494	0	2,249	0	16.00
20.00	NURSING SCHOOL	73,362	59,793	0	5,674	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	35,963	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	34,781	0	0	0	0	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
23.01	PARAMED ED PRGM-RADIOLOGY	6,384	800	0	26	0	23.01
23.02	PARAMED ED PRGM-LABORATORY	2,198	800	0	0	0	23.02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	544,762	138,963	19,823	51,965	114,621	30.00
31.00	INTENSIVE CARE UNIT	151,211	35,399	2,496	15,163	16,871	31.00
40.00	SUBPROVIDER - IPF	117,469	39,241	1,091	13,632	28,249	40.00
41.00	SUBPROVIDER - IRF	57,145	8,403	1,203	6,247	14,642	41.00
43.00	NURSERY	17,005	4,288	185	1,394	0	43.00
44.00	SKILLED NURSING FACILITY	55,458	14,092	1,549	4,781	17,791	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	431,445	68,863	5,977	27,895	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	46,289	7,154	843	5,527	0	52.00
53.00	ANESTHESIOLOGY	12,970	2,024	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	298,321	56,784	3,424	11,594	0	54.00
60.00	LABORATORY	186,732	19,537	52	3,855	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	42,376	597	0	61	0	62.00
65.00	RESPIRATORY THERAPY	74,466	10,127	21	4,151	0	65.00
66.00	PHYSICAL THERAPY	88,423	13,059	644	3,526	0	66.00
67.00	OCCUPATIONAL THERAPY	26,100	2,545	0	0	0	67.00
68.00	SPEECH PATHOLOGY	9,096	862	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	99,157	15,794	940	1,581	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	12,099	3,388	368	756	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	210,692	14,372	294	1,505	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	261,075	21,300	436	2,259	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	414,646	7,247	0	1,838	0	73.00
74.00	RENAL DIALYSIS	19,295	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	23,570	0	0	36	0	88.00
91.00	EMERGENCY	180,824	51,403	5,809	18,505	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	55,694	7,634	0	10,439	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	71,917	12,002	54	1,307	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	4,407,119	691,094	45,432	208,229	192,174	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	192	8,814	163	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	94,190	33,572	0	0	0	192.00
192.01	FASTCARE	17,020	0	0	0	0	192.01
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	ADULT DAY CARE	0	0	0	0	0	193.01
193.02	DENMAN SERVICES	237	4,853	0	1,259	0	193.02
193.03	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	UNUSED SPACE	334	36,457	0	0	0	193.04
193.05	HEALTH EDUCATION	524	0	0	0	0	193.05
193.06	RENTED SPACE	3,403	40,718	0	5,753	0	193.06
193.07	AUGUSTA PHARMACY	29,890	0	0	0	0	193.07
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)	4,552,909	815,508	45,595	215,241	192,174	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part II | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL		
		11.00	13.00	16.00	20.00		
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT						1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT						1.03
1.04	CAP REL COSTS-14TH STREET						1.04
1.05	CAP REL COSTS-MOB PHASE I						1.05
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	124,603					11.00
13.00	NURSING ADMINISTRATION	8,144	1,016,115				13.00
16.00	MEDICAL RECORDS & LIBRARY	4,614	0	261,091			16.00
20.00	NURSING SCHOOL	5,329	0	0	415,129		20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0			21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,710	0	0			22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
23.01	PARAMED ED PRGM-RADIOLOGY	381	0	0			23.01
23.02	PARAMED ED PRGM-LABORATORY	94	0	0			23.02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	26,349	372,195	154,325			30.00
31.00	INTENSIVE CARE UNIT	5,977	84,433	22,716			31.00
40.00	SUBPROVIDER - IPF	6,188	87,408	38,036			40.00
41.00	SUBPROVIDER - IRF	2,560	36,160	19,715			41.00
43.00	NURSERY	615	8,689	702			43.00
44.00	SKILLED NURSING FACILITY	2,872	40,567	23,955			44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	12,598	177,951	0			50.00
52.00	DELIVERY ROOM & LABOR ROOM	1,813	25,606	0			52.00
53.00	ANESTHESIOLOGY	430	6,074	0			53.00
54.00	RADIOLOGY-DIAGNOSTIC	7,565	0	0			54.00
60.00	LABORATORY	6,379	0	0			60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	344	0	0			62.00
65.00	RESPIRATORY THERAPY	3,351	0	0			65.00
66.00	PHYSICAL THERAPY	3,226	0	0			66.00
67.00	OCCUPATIONAL THERAPY	961	0	0			67.00
68.00	SPEECH PATHOLOGY	398	0	0			68.00
69.00	ELECTROCARDIOLOGY	2,234	0	0			69.00
70.00	ELECTROENCEPHALOGRAPHY	621	0	0			70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	856	0	0			71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	1,269	0	0			72.00
73.00	DRUGS CHARGED TO PATIENTS	4,157	0	0			73.00
74.00	RENAL DIALYSIS	0	0	0			74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0			88.00
91.00	EMERGENCY	6,945	98,109	1,642			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	2,207	31,174	0			101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0			113.00
116.00	HOSPICE	2,822	39,858	0			116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	123,009	1,008,224	261,091	0		118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	PHYSICIANS' PRIVATE OFFICES	1,567	0	0			192.00
192.01	FASTCARE	0	7,891	0			192.01
193.00	NONPAID WORKERS	0	0	0			193.00
193.01	ADULT DAY CARE	0	0	0			193.01
193.02	DENMAN SERVICES	0	0	0			193.02
193.03	MEALS ON WHEELS	0	0	0			193.03
193.04	UNUSED SPACE	0	0	0			193.04
193.05	HEALTH EDUCATION	27	0	0			193.05
193.06	RENTED SPACE	0	0	0			193.06
193.07	AUGUSTA PHARMACY	0	0	0			193.07
200.00	Cross Foot Adjustments				415,129		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	124,603	1,016,115	261,091	415,129		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part II Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
		21.00	22.00	23.00	23.01	23.02	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT						1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT						1.03
1.04	CAP REL COSTS-14TH STREET						1.04
1.05	CAP REL COSTS-MOB PHASE I						1.05
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION						13.00
16.00	MEDICAL RECORDS & LIBRARY						16.00
20.00	NURSING SCHOOL						20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	40,033					21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD		36,509				22.00
23.00	PARAMED ED PRGM-(SPECIFY)			0			23.00
23.01	PARAMED ED PRGM-RADIOLOGY				12,284		23.01
23.02	PARAMED ED PRGM-LABORATORY					4,539	23.02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS						30.00
31.00	INTENSIVE CARE UNIT						31.00
40.00	SUBPROVIDER - IPF						40.00
41.00	SUBPROVIDER - IRF						41.00
43.00	NURSERY						43.00
44.00	SKILLED NURSING FACILITY						44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM						50.00
52.00	DELIVERY ROOM & LABOR ROOM						52.00
53.00	ANESTHESIOLOGY						53.00
54.00	RADIOLOGY-DIAGNOSTIC						54.00
60.00	LABORATORY						60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS						62.00
65.00	RESPIRATORY THERAPY						65.00
66.00	PHYSICAL THERAPY						66.00
67.00	OCCUPATIONAL THERAPY						67.00
68.00	SPEECH PATHOLOGY						68.00
69.00	ELECTROCARDIOLOGY						69.00
70.00	ELECTROENCEPHALOGRAPHY						70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS						71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS						72.00
73.00	DRUGS CHARGED TO PATIENTS						73.00
74.00	RENAL DIALYSIS						74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC						88.00
91.00	EMERGENCY						91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY						101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE						116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	0	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190.00
192.00	PHYSICIANS' PRIVATE OFFICES						192.00
192.01	FASTCARE						192.01
193.00	NONPAID WORKERS						193.00
193.01	ADULT DAY CARE						193.01
193.02	DENMAN SERVICES						193.02
193.03	MEALS ON WHEELS						193.03
193.04	UNUSED SPACE						193.04
193.05	HEALTH EDUCATION						193.05
193.06	RENTED SPACE						193.06
193.07	AUGUSTA PHARMACY						193.07
200.00	Cross Foot Adjustments	40,033	36,509	0	12,284	4,539	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part II Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
		21.00	22.00	23.00	23.01	23.02	
202.00	TOTAL (sum lines 118-201)	40,033	36,509	0	12,284	4,539	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part II | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
1.01	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT					1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT					1.03
1.04	CAP REL COSTS-14TH STREET					1.04
1.05	CAP REL COSTS-MOB PHASE I					1.05
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
6.00	MAINTENANCE & REPAIRS					6.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
20.00	NURSING SCHOOL					20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23.00	PARAMED ED PRGM-(SPECIFY)					23.00
23.01	PARAMED ED PRGM-RADIOLOGY					23.01
23.02	PARAMED ED PRGM-LABORATORY					23.02
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	2,323,124	0	2,323,124		30.00
31.00	INTENSIVE CARE UNIT	716,682	0	716,682		31.00
40.00	SUBPROVIDER - IPF	359,694	0	359,694		40.00
41.00	SUBPROVIDER - IRF	213,284	0	213,284		41.00
43.00	NURSERY	60,606	0	60,606		43.00
44.00	SKILLED NURSING FACILITY	236,280	0	236,280		44.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	2,573,586	0	2,573,586		50.00
52.00	DELIVERY ROOM & LABOR ROOM	147,095	0	147,095		52.00
53.00	ANESTHESIOLOGY	106,930	0	106,930		53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,041,243	0	2,041,243		54.00
60.00	LABORATORY	541,155	0	541,155		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	45,075	0	45,075		62.00
65.00	RESPIRATORY THERAPY	114,258	0	114,258		65.00
66.00	PHYSICAL THERAPY	176,686	0	176,686		66.00
67.00	OCCUPATIONAL THERAPY	38,122	0	38,122		67.00
68.00	SPEECH PATHOLOGY	12,601	0	12,601		68.00
69.00	ELECTROCARDIOLOGY	850,406	0	850,406		69.00
70.00	ELECTROENCEPHALOGRAPHY	34,788	0	34,788		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	289,001	0	289,001		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	377,154	0	377,154		72.00
73.00	DRUGS CHARGED TO PATIENTS	620,301	0	620,301		73.00
74.00	RENAL DIALYSIS	19,295	0	19,295		74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	25,023	0	25,023		88.00
91.00	EMERGENCY	731,575	0	731,575		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
	OTHER REIMBURSABLE COST CENTERS					
101.00	HOME HEALTH AGENCY	129,018	0	129,018		101.00
	SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE	0	0	0		113.00
116.00	HOSPICE	160,111	0	160,111		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	12,943,093	0	12,943,093		118.00
	NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,883	0	15,883		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	155,302	0	155,302		192.00
192.01	FASTCARE	31,283	0	31,283		192.01
193.00	NONPAID WORKERS	0	0	0		193.00
193.01	ADULT DAY CARE	0	0	0		193.01
193.02	DENMAN SERVICES	14,654	0	14,654		193.02
193.03	MEALS ON WHEELS	0	0	0		193.03
193.04	UNUSED SPACE	48,483	0	48,483		193.04
193.05	HEALTH EDUCATION	610	0	610		193.05
193.06	RENTED SPACE	169,160	0	169,160		193.06
193.07	AUGUSTA PHARMACY	31,007	0	31,007		193.07
200.00	Cross Foot Adjustments	508,494	0	508,494		200.00
201.00	Negative Cost Centers	0	0	0		201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part II Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
202.00	TOTAL (sum lines 118-201)	13,917,969	0	13,917,969		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B-1 | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BUILDING & FIXT (SQUARE FEET)	NEW BUILDING & FIXT (SQUARE FEET)	14TH STREET (SQUARE FEET)	
		1.00	1.01	1.02	1.03	1.04	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	18,141				1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	0	0	130,726			1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	0	0	0	447,543		1.03
1.04	CAP REL COSTS-14TH STREET	0	0	0	0	258,597	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	0	1.05
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	0	0	5,777	23,484	642	4.00
5.00	ADMINISTRATIVE & GENERAL	0	0	34,831	82,978	61,021	5.00
6.00	MAINTENANCE & REPAIRS	0	3,821	16,552	54,250	57,219	6.00
8.00	LAUNDRY & LINEN SERVICE	0	0	1,779	0	376	8.00
9.00	HOUSEKEEPING	0	0	3,641	368	2,578	9.00
10.00	DIETARY	0	0	0	11,305	3,876	10.00
11.00	CAFETERIA	0	0	0	3,432	5,119	11.00
13.00	NURSING ADMINISTRATION	0	0	3,120	363	3,479	13.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	497	7,075	1,133	16.00
20.00	NURSING SCHOOL	0	14,320	0	20,761	3,493	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
23.01	PARAMED ED PRGM-RADIOLOGY	0	0	0	516	0	23.01
23.02	PARAMED ED PRGM-LABORATORY	0	0	516	0	0	23.02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	0	5,425	84,224	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	10,485	12,352	0	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	25,315	40.00
41.00	SUBPROVIDER - IRF	0	0	871	4,550	0	41.00
43.00	NURSERY	0	0	0	2,766	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	9,091	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	10,557	25,570	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	4,615	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	628	678	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	33,259	0	54.00
60.00	LABORATORY	0	0	101	12,167	336	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	385	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	6,533	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	2,123	6,302	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	1,642	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	556	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	6,248	3,941	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	2,186	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,849	5,423	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,704	8,037	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	322	4,026	327	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	EMERGENCY	0	0	7,193	17,568	8,400	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	0	0	0	4,925	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	0	0	0	7,743	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	18,141	126,583	430,579	199,442	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,545	0	3,141	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	21,658	192.00
192.01	FASTCARE	0	0	0	0	0	192.01
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	ADULT DAY CARE	0	0	0	0	0	193.01
193.02	DENMAN SERVICES	0	0	0	1,000	2,131	193.02
193.03	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	UNUSED SPACE	0	0	1,174	223	22,122	193.04
193.05	HEALTH EDUCATION	0	0	0	0	0	193.05
193.06	RENTED SPACE	0	0	424	15,741	10,103	193.06
193.07	AUGUSTA PHARMACY	0	0	0	0	0	193.07
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B-1 | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BUILDING & FIXT (SQUARE FEET)	NEW BUILDING & FIXT (SQUARE FEET)	14TH STREET (SQUARE FEET)	
		1.00	1.01	1.02	1.03	1.04	
202.00	Cost to be allocated (per Wkst. B, Part I)	0	26,180	290,496	3,267,920	87,147	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	1.443140	2.222175	7.301913	0.336999	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)						204.00
205.00	Unit cost multiplier (Wkst. B, Part II)						205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B-1 | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		MOB PHASE I (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.05	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT						1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT						1.03
1.04	CAP REL COSTS-14TH STREET						1.04
1.05	CAP REL COSTS-MOB PHASE I	11,672					1.05
2.00	CAP REL COSTS-MVBLE EQUIP		10,266,957				2.00
4.00	EMPLOYEE BENEFITS	0	179,412	90,194,250			4.00
5.00	ADMINISTRATIVE & GENERAL	0	3,831,265	11,669,208	-40,256,117	159,618,605	5.00
6.00	MAINTENANCE & REPAIRS	0	145,304	2,397,112	0	7,150,678	6.00
8.00	LAUNDRY & LINEN SERVICE	0	6,684	61,019	0	1,097,230	8.00
9.00	HOUSEKEEPING	0	104,266	2,075,381	0	2,859,624	9.00
10.00	DIETARY	0	16,854	756,729	0	2,152,631	10.00
11.00	CAFETERIA	0	0	1,378,609	0	2,565,531	11.00
13.00	NURSING ADMINISTRATION	0	761,142	4,782,292	0	7,320,765	13.00
16.00	MEDICAL RECORDS & LIBRARY	0	95,771	1,636,916	0	3,013,727	16.00
20.00	NURSING SCHOOL	0	85,428	3,172,954	0	2,571,936	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,012,486	0	1,260,810	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	18	0	0	1,219,369	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
23.01	PARAMED ED PRGM-RADIOLOGY	0	0	230,179	0	223,817	23.01
23.02	PARAMED ED PRGM-LABORATORY	0	0	74,690	0	77,062	23.02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	218,659	13,948,047	0	19,100,304	30.00
31.00	INTENSIVE CARE UNIT	0	255,935	3,714,810	0	5,301,182	31.00
40.00	SUBPROVIDER - IPF	0	6,906	3,232,828	0	4,118,253	40.00
41.00	SUBPROVIDER - IRF	0	26,688	1,384,023	0	2,003,390	41.00
43.00	NURSERY	0	5,880	421,868	0	596,168	43.00
44.00	SKILLED NURSING FACILITY	0	3,131	1,424,400	0	1,944,252	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	8,298	1,581,828	6,996,117	0	15,125,695	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	45,398	1,133,158	0	1,622,808	52.00
53.00	ANESTHESIOLOGY	0	79,043	159,862	0	454,696	53.00
54.00	RADIOLOGY-DIAGNOSTIC	3,374	1,396,065	4,646,293	0	10,458,590	54.00
60.00	LABORATORY	0	224,895	3,043,849	0	6,546,483	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	209,200	0	1,485,639	62.00
65.00	RESPIRATORY THERAPY	0	0	1,896,744	0	2,610,655	65.00
66.00	PHYSICAL THERAPY	0	8,224	2,216,859	0	3,099,965	66.00
67.00	OCCUPATIONAL THERAPY	0	2,012	714,007	0	915,012	67.00
68.00	SPEECH PATHOLOGY	0	0	251,095	0	318,881	68.00
69.00	ELECTROCARDIOLOGY	0	687,606	1,408,440	0	3,476,281	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	11,645	284,164	0	424,162	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	30,495	270,116	0	7,386,475	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	45,192	400,289	0	9,152,817	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	151,468	2,953,451	0	14,536,746	73.00
74.00	RENAL DIALYSIS	0	0	0	0	676,437	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	352,430	0	826,310	88.00
91.00	EMERGENCY	0	207,079	3,915,267	0	6,339,346	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	15,216	1,271,233	0	1,952,543	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	23,515	1,543,878	0	2,521,270	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,672	10,253,024	87,040,003	-40,256,117	154,507,540	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	6,714	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	8,349	2,584,084	0	3,302,130	192.00
192.01	FASTCARE	0	4,823	394,582	0	596,685	192.01
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	ADULT DAY CARE	0	0	0	0	0	193.01
193.02	DENMAN SERVICES	0	287	0	0	8,305	193.02
193.03	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	UNUSED SPACE	0	0	0	0	11,692	193.04
193.05	HEALTH EDUCATION	0	0	14,713	0	18,366	193.05
193.06	RENTED SPACE	0	0	0	0	119,286	193.06
193.07	AUGUSTA PHARMACY	0	474	160,868	0	1,047,887	193.07
200.00	Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B-1 | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		MOB PHASE I (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.05	2.00	4.00	5A	5.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	57,337	10,188,889	22,121,207		40,256,117	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	4.912354	0.992396	0.245262		0.252202	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			362,580		4,552,909	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.004020		0.028524	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B-1 | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		6.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT						1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT						1.03
1.04	CAP REL COSTS-14TH STREET						1.04
1.05	CAP REL COSTS-MOB PHASE I						1.05
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS	526,104					6.00
8.00	LAUNDRY & LINEN SERVICE	2,155	1,552,680				8.00
9.00	HOUSEKEEPING	6,587	0	106,708			9.00
10.00	DIETARY	15,181	7,600	1,683	235,310		10.00
11.00	CAFETERIA	8,551	0	2,896	0	404,847	11.00
13.00	NURSING ADMINISTRATION	6,962	0	1,500	0	26,461	13.00
16.00	MEDICAL RECORDS & LIBRARY	8,705	0	1,115	0	14,991	16.00
20.00	NURSING SCHOOL	38,574	0	2,813	0	17,313	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	5,557	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
23.01	PARAMED ED PRGM-RADIOLOGY	516	0	13	0	1,237	23.01
23.02	PARAMED ED PRGM-LABORATORY	516	0	0	0	307	23.02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	89,649	674,983	25,764	140,349	85,609	30.00
31.00	INTENSIVE CARE UNIT	22,837	84,987	7,517	20,658	19,421	31.00
40.00	SUBPROVIDER - IPF	25,315	37,165	6,758	34,590	20,105	40.00
41.00	SUBPROVIDER - IRF	5,421	40,964	3,097	17,928	8,317	41.00
43.00	NURSERY	2,766	6,304	691	0	1,999	43.00
44.00	SKILLED NURSING FACILITY	9,091	52,762	2,370	21,785	9,331	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	44,425	203,558	13,829	0	40,931	50.00
52.00	DELIVERY ROOM & LABOR ROOM	4,615	28,720	2,740	0	5,890	52.00
53.00	ANESTHESIOLOGY	1,306	0	0	0	1,397	53.00
54.00	RADIOLOGY-DIAGNOSTIC	36,633	116,599	5,748	0	24,578	54.00
60.00	LABORATORY	12,604	1,768	1,911	0	20,727	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	385	0	30	0	1,119	62.00
65.00	RESPIRATORY THERAPY	6,533	700	2,058	0	10,888	65.00
66.00	PHYSICAL THERAPY	8,425	21,930	1,748	0	10,483	66.00
67.00	OCCUPATIONAL THERAPY	1,642	0	0	0	3,121	67.00
68.00	SPEECH PATHOLOGY	556	0	0	0	1,292	68.00
69.00	ELECTROCARDIOLOGY	10,189	32,014	784	0	7,259	69.00
70.00	ELECTROENCEPHALOGRAPHY	2,186	12,541	375	0	2,018	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,272	10,026	746	0	2,782	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	13,741	14,858	1,120	0	4,122	72.00
73.00	DRUGS CHARGED TO PATIENTS	4,675	0	911	0	13,508	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	18	0	0	88.00
91.00	EMERGENCY	33,161	197,810	9,174	0	22,566	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	4,925	0	5,175	0	7,170	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	7,743	1,836	648	0	9,168	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	445,842	1,547,125	103,232	235,310	399,667	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,686	5,555	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	21,658	0	0	0	5,092	192.00
192.01	FASTCARE	0	0	0	0	0	192.01
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	ADULT DAY CARE	0	0	0	0	0	193.01
193.02	DENMAN SERVICES	3,131	0	624	0	0	193.02
193.03	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	UNUSED SPACE	23,519	0	0	0	0	193.04
193.05	HEALTH EDUCATION	0	0	0	0	88	193.05
193.06	RENTED SPACE	26,268	0	2,852	0	0	193.06
193.07	AUGUSTA PHARMACY	0	0	0	0	0	193.07
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)	8,954,093	1,410,631	3,692,935	3,019,054	3,458,322	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B-1 | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		6.00	8.00	9.00	10.00	11.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	17.019625	0.908514	34.607855	12.830113	8.542294	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	815,508	45,595	215,241	192,174	124,603	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.550089	0.029365	2.017103	0.816684	0.307778	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B-1 | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	
		13.00	16.00	20.00	21.00	22.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT						1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT						1.03
1.04	CAP REL COSTS-14TH STREET						1.04
1.05	CAP REL COSTS-MOB PHASE I						1.05
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION	1,676,103					13.00
16.00	MEDICAL RECORDS & LIBRARY	0	107,510				16.00
20.00	NURSING SCHOOL	0	0	28,086			20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		21,396		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0			21,396	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
23.01	PARAMED ED PRGM-RADIOLOGY	0	0				23.01
23.02	PARAMED ED PRGM-LABORATORY	0	0				23.02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	613,945	63,547	19,821	14,960	14,960	30.00
31.00	INTENSIVE CARE UNIT	139,274	9,354	2,316	645	645	31.00
40.00	SUBPROVIDER - IPF	144,182	15,662	1,736	546	546	40.00
41.00	SUBPROVIDER - IRF	59,646	8,118	142	761	761	41.00
43.00	NURSERY	14,333	289	369	397	397	43.00
44.00	SKILLED NURSING FACILITY	66,916	9,864	0	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	293,533	0	1,111	1,357	1,357	50.00
52.00	DELIVERY ROOM & LABOR ROOM	42,238	0	1,078	0	0	52.00
53.00	ANESTHESIOLOGY	10,019	0	0	50	50	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	215	215	54.00
60.00	LABORATORY	0	0	0	215	215	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	40	761	761	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	116	116	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	EMERGENCY	161,832	676	1,433	1,373	1,373	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	51,422	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	65,746	0	40	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,663,086	107,510	28,086	21,396	21,396	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	FASTCARE	13,017	0	0	0	0	192.01
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	ADULT DAY CARE	0	0	0	0	0	193.01
193.02	DENMAN SERVICES	0	0	0	0	0	193.02
193.03	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	UNUSED SPACE	0	0	0	0	0	193.04
193.05	HEALTH EDUCATION	0	0	0	0	0	193.05
193.06	RENTED SPACE	0	0	0	0	0	193.06
193.07	AUGUSTA PHARMACY	0	0	0	0	0	193.07

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B-1 | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	
		13.00	16.00	20.00	21.00	22.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	9,563,518	4,088,597	4,122,343	1,578,789	1,574,366	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5.705806	38.029923	146.775725	73.788979	73.582258	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,016,115	261,091	415,129	40,033	36,509	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.606237	2.428528	14.780638	1.871051	1.706347	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B-1 | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)		
		23.00	23.01	23.02		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
1.01	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT					1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT					1.03
1.04	CAP REL COSTS-14TH STREET					1.04
1.05	CAP REL COSTS-MOB PHASE I					1.05
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
6.00	MAINTENANCE & REPAIRS					6.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
20.00	NURSING SCHOOL					20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0				23.00
23.01	PARAMED ED PRGM-RADIOLOGY	0	100			23.01
23.02	PARAMED ED PRGM-LABORATORY	0	0	100		23.02
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	0	0	0		30.00
31.00	INTENSIVE CARE UNIT	0	0	0		31.00
40.00	SUBPROVIDER - IPF	0	0	0		40.00
41.00	SUBPROVIDER - IRF	0	0	0		41.00
43.00	NURSERY	0	0	0		43.00
44.00	SKILLED NURSING FACILITY	0	0	0		44.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	100	0		54.00
60.00	LABORATORY	0	0	100		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	RENAL DIALYSIS	0	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
	OTHER REIMBURSABLE COST CENTERS					
101.00	HOME HEALTH AGENCY	0	0	0		101.00
	SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE	0	0	0		113.00
116.00	HOSPICE	0	0	0		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	100	100		118.00
	NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	FASTCARE	0	0	0		192.01
193.00	NONPAID WORKERS	0	0	0		193.00
193.01	ADULT DAY CARE	0	0	0		193.01
193.02	DENMAN SERVICES	0	0	0		193.02
193.03	MEALS ON WHEELS	0	0	0		193.03
193.04	UNUSED SPACE	0	0	0		193.04
193.05	HEALTH EDUCATION	0	0	0		193.05
193.06	RENTED SPACE	0	0	0		193.06
193.07	AUGUSTA PHARMACY	0	0	0		193.07
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B-1 | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)		
		23.00	23.01	23.02		
202.00	Cost to be allocated (per Wkst. B, Part I)	0	300,063	107,901		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	3,000.630000	1,079.010000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	12,284	4,539		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	122.840000	45.390000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet C Part I Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	38,309,049		38,309,049	14,163	38,323,212	30.00
31.00	INTENSIVE CARE UNIT	9,285,466		9,285,466	13,874	9,299,340	31.00
40.00	SUBPROVIDER - IPF	8,144,022		8,144,022	0	8,144,022	40.00
41.00	SUBPROVIDER - IRF	3,716,271		3,716,271	12,718	3,728,989	41.00
43.00	NURSERY	987,248		987,248	0	987,248	43.00
44.00	SKILLED NURSING FACILITY	3,835,426		3,835,426	530	3,835,956	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	22,547,605		22,547,605	77,832	22,625,437	50.00
52.00	DELIVERY ROOM & LABOR ROOM	2,681,088		2,681,088	0	2,681,088	52.00
53.00	ANESTHESIOLOGY	660,699		660,699	0	660,699	53.00
54.00	RADIOLOGY-DIAGNOSTIC	14,534,621		14,534,621	0	14,534,621	54.00
60.00	LABORATORY	8,764,733		8,764,733	0	8,764,733	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,877,470		1,877,470	0	1,877,470	62.00
65.00	RESPIRATORY THERAPY	3,545,123	0	3,545,123	10,538	3,555,661	65.00
66.00	PHYSICAL THERAPY	4,195,140	0	4,195,140	0	4,195,140	66.00
67.00	OCCUPATIONAL THERAPY	1,200,386	0	1,200,386	0	1,200,386	67.00
68.00	SPEECH PATHOLOGY	419,803	0	419,803	0	419,803	68.00
69.00	ELECTROCARDIOLOGY	4,650,517		4,650,517	12,136	4,662,653	69.00
70.00	ELECTROENCEPHALOGRAPHY	609,952		609,952	6,504	616,456	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,465,856		9,465,856	0	9,465,856	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	11,782,514		11,782,514	0	11,782,514	72.00
73.00	DRUGS CHARGED TO PATIENTS	18,429,426		18,429,426	0	18,429,426	73.00
74.00	RENAL DIALYSIS	847,036		847,036	0	847,036	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,035,330		1,035,330	0	1,035,330	88.00
91.00	EMERGENCY	10,351,920		10,351,920	106,634	10,458,554	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	5,764,117		5,764,117		5,764,117	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	3,062,548		3,062,548		3,062,548	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	3,772,337		3,772,337		3,772,337	116.00
200.00	Subtotal (see instructions)	194,475,703	0	194,475,703	254,929	194,730,632	200.00
201.00	Less Observation Beds	5,764,117		5,764,117		5,764,117	201.00
202.00	Total (see instructions)	188,711,586	0	188,711,586	254,929	188,966,515	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet C Part I Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	55,416,410		55,416,410			30.00
31.00	INTENSIVE CARE UNIT	28,072,691		28,072,691			31.00
40.00	SUBPROVIDER - IPF	15,559,840		15,559,840			40.00
41.00	SUBPROVIDER - IRF	4,562,049		4,562,049			41.00
43.00	NURSERY	1,942,469		1,942,469			43.00
44.00	SKILLED NURSING FACILITY	4,307,169		4,307,169			44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	20,995,567	40,728,150	61,723,717	0.365299	0.000000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	3,407,806	349,938	3,757,744	0.713483	0.000000	52.00
53.00	ANESTHESIOLOGY	5,781,252	7,587,616	13,368,868	0.049421	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	19,252,379	78,696,087	97,948,466	0.148390	0.000000	54.00
60.00	LABORATORY	27,124,300	40,394,107	67,518,407	0.129812	0.000000	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,268,784	1,215,330	4,484,114	0.418694	0.000000	62.00
65.00	RESPIRATORY THERAPY	5,237,868	2,369,142	7,607,010	0.466034	0.000000	65.00
66.00	PHYSICAL THERAPY	4,283,984	3,446,651	7,730,635	0.542664	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	2,155,470	465,330	2,620,800	0.458023	0.000000	67.00
68.00	SPEECH PATHOLOGY	1,013,833	493,815	1,507,648	0.278449	0.000000	68.00
69.00	ELECTROCARDIOLOGY	26,625,896	26,974,415	53,600,311	0.086763	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	303,641	2,332,510	2,636,151	0.231380	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,047,988	20,148,623	41,196,611	0.229773	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	19,417,908	9,383,045	28,800,953	0.409102	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	53,481,213	40,442,671	93,923,884	0.196217	0.000000	73.00
74.00	RENAL DIALYSIS	1,529,711	309,405	1,839,116	0.460567	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	709,074	709,074			88.00
91.00	EMERGENCY	8,421,461	22,195,858	30,617,319	0.338107	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1,868,837	9,248,263	11,117,100	0.518491	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	1,914,820	1,914,820			101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	0	3,569,186	3,569,186			116.00
200.00	Subtotal (see instructions)	335,078,526	312,974,036	648,052,562			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	335,078,526	312,974,036	648,052,562			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet C Part I Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	PPS Inpatient Ratio	
		11.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	ADULTS & PEDIATRICS		30.00
31.00	INTENSIVE CARE UNIT		31.00
40.00	SUBPROVIDER - IPF		40.00
41.00	SUBPROVIDER - IRF		41.00
43.00	NURSERY		43.00
44.00	SKILLED NURSING FACILITY		44.00
	ANCILLARY SERVICE COST CENTERS		
50.00	OPERATING ROOM	0.366560	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.713483	52.00
53.00	ANESTHESIOLOGY	0.049421	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.148390	54.00
60.00	LABORATORY	0.129812	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.418694	62.00
65.00	RESPIRATORY THERAPY	0.467419	65.00
66.00	PHYSICAL THERAPY	0.542664	66.00
67.00	OCCUPATIONAL THERAPY	0.458023	67.00
68.00	SPEECH PATHOLOGY	0.278449	68.00
69.00	ELECTROCARDIOLOGY	0.086989	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.233847	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.229773	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.409102	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.196217	73.00
74.00	RENAL DIALYSIS	0.460567	74.00
	OUTPATIENT SERVICE COST CENTERS		
88.00	RURAL HEALTH CLINIC		88.00
91.00	EMERGENCY	0.341589	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.518491	92.00
	OTHER REIMBURSABLE COST CENTERS		
101.00	HOME HEALTH AGENCY		101.00
	SPECIAL PURPOSE COST CENTERS		
113.00	INTEREST EXPENSE		113.00
116.00	HOSPICE		116.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet C Part I Date/Time Prepared: 4/2/2012 1:04 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	38,309,049		38,309,049	0	0	30.00
31.00	INTENSIVE CARE UNIT	9,285,466		9,285,466	0	0	31.00
40.00	SUBPROVIDER - IPF	8,144,022		8,144,022	0	0	40.00
41.00	SUBPROVIDER - IRF	3,716,271		3,716,271	0	0	41.00
43.00	NURSERY	987,248		987,248	0	0	43.00
44.00	SKILLED NURSING FACILITY	3,835,426		3,835,426	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	22,547,605		22,547,605	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	2,681,088		2,681,088	0	0	52.00
53.00	ANESTHESIOLOGY	660,699		660,699	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	14,534,621		14,534,621	0	0	54.00
60.00	LABORATORY	8,764,733		8,764,733	0	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,877,470		1,877,470	0	0	62.00
65.00	RESPIRATORY THERAPY	3,545,123	0	3,545,123	0	0	65.00
66.00	PHYSICAL THERAPY	4,195,140	0	4,195,140	0	0	66.00
67.00	OCCUPATIONAL THERAPY	1,200,386	0	1,200,386	0	0	67.00
68.00	SPEECH PATHOLOGY	419,803	0	419,803	0	0	68.00
69.00	ELECTROCARDIOLOGY	4,650,517		4,650,517	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	609,952		609,952	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,465,856		9,465,856	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	11,782,514		11,782,514	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	18,429,426		18,429,426	0	0	73.00
74.00	RENAL DIALYSIS	847,036		847,036	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,035,330		1,035,330	0	0	88.00
91.00	EMERGENCY	10,351,920		10,351,920	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	5,764,117		5,764,117		0	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	3,062,548		3,062,548		0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	3,772,337		3,772,337		0	116.00
200.00	Subtotal (see instructions)	194,475,703	0	194,475,703	0	0	200.00
201.00	Less Observation Beds	5,764,117		5,764,117		0	201.00
202.00	Total (see instructions)	188,711,586	0	188,711,586	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet C Part I Date/Time Prepared: 4/2/2012 1:04 pm

Title XIX | Hospital | Cost

	Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	55,416,410		55,416,410			30.00
31.00	INTENSIVE CARE UNIT	28,072,691		28,072,691			31.00
40.00	SUBPROVIDER - IPF	15,559,840		15,559,840			40.00
41.00	SUBPROVIDER - IRF	4,562,049		4,562,049			41.00
43.00	NURSERY	1,942,469		1,942,469			43.00
44.00	SKILLED NURSING FACILITY	4,307,169		4,307,169			44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	20,995,567	40,728,150	61,723,717	0.365299	0.000000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	3,407,806	349,938	3,757,744	0.713483	0.000000	52.00
53.00	ANESTHESIOLOGY	5,781,252	7,587,616	13,368,868	0.049421	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	19,252,379	78,696,087	97,948,466	0.148390	0.000000	54.00
60.00	LABORATORY	27,124,300	40,394,107	67,518,407	0.129812	0.000000	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,268,784	1,215,330	4,484,114	0.418694	0.000000	62.00
65.00	RESPIRATORY THERAPY	5,237,868	2,369,142	7,607,010	0.466034	0.000000	65.00
66.00	PHYSICAL THERAPY	4,283,984	3,446,651	7,730,635	0.542664	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	2,155,470	465,330	2,620,800	0.458023	0.000000	67.00
68.00	SPEECH PATHOLOGY	1,013,833	493,815	1,507,648	0.278449	0.000000	68.00
69.00	ELECTROCARDIOLOGY	26,625,896	26,974,415	53,600,311	0.086763	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	303,641	2,332,510	2,636,151	0.231380	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,047,988	20,148,623	41,196,611	0.229773	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	19,417,908	9,383,045	28,800,953	0.409102	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	53,481,213	40,442,671	93,923,884	0.196217	0.000000	73.00
74.00	RENAL DIALYSIS	1,529,711	309,405	1,839,116	0.460567	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	709,074	709,074	1.460116	0.000000	88.00
91.00	EMERGENCY	8,421,461	22,195,858	30,617,319	0.338107	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1,868,837	9,248,263	11,117,100	0.518491	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	1,914,820	1,914,820			101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	0	3,569,186	3,569,186			116.00
200.00	Subtotal (see instructions)	335,078,526	312,974,036	648,052,562			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	335,078,526	312,974,036	648,052,562			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet C Part I Date/Time Prepared: 4/2/2012 1:04 pm

Title XIX | Hospital | Cost

	Cost Center Description	PPS Inpatient Ratio		
		11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
40.00	SUBPROVIDER - IPF			40.00
41.00	SUBPROVIDER - IRF			41.00
43.00	NURSERY			43.00
44.00	SKILLED NURSING FACILITY			44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0.000000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	LABORATORY	0.000000		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	RESPIRATORY THERAPY	0.000000		65.00
66.00	PHYSICAL THERAPY	0.000000		66.00
67.00	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	SPEECH PATHOLOGY	0.000000		68.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	RENAL DIALYSIS	0.000000		74.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	0.000000		88.00
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
	OTHER REIMBURSABLE COST CENTERS			
101.00	HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE			113.00
116.00	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: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part I Date/Time Prepared: 4/2/2012 1:04 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	2,323,124	0	2,323,124	43,914	52.90	30.00
31.00	INTENSIVE CARE UNIT	716,682		716,682	5,488	130.59	31.00
40.00	SUBPROVIDER - IPF	359,694	0	359,694	9,347	38.48	40.00
41.00	SUBPROVIDER - IRF	213,284	0	213,284	4,835	44.11	41.00
43.00	NURSERY	60,606		60,606	2,450	24.74	43.00
44.00	SKILLED NURSING FACILITY	236,280		236,280	5,896	40.07	44.00
200.00	Total (lines 30-199)	3,909,670		3,909,670	71,930		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part I Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	24,041	1,271,769		30.00
31.00	INTENSIVE CARE UNIT	2,819	368,133		31.00
40.00	SUBPROVIDER - IPF	1,507	57,989		40.00
41.00	SUBPROVIDER - IRF	3,196	140,976		41.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	4,882	195,622		44.00
200.00	Total (lines 30-199)	36,445	2,034,489		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part II Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,573,586	61,723,717	0.041695	11,018,555	459,419	50.00
52.00	DELIVERY ROOM & LABOR ROOM	147,095	3,757,744	0.039144	12,343	483	52.00
53.00	ANESTHESIOLOGY	106,930	13,368,868	0.007998	2,770,358	22,157	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,041,243	97,948,466	0.020840	18,020,836	375,554	54.00
60.00	LABORATORY	541,155	67,518,407	0.008015	16,989,565	136,171	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	45,075	4,484,114	0.010052	2,148,808	21,600	62.00
65.00	RESPIRATORY THERAPY	114,258	7,607,010	0.015020	3,722,970	55,919	65.00
66.00	PHYSICAL THERAPY	176,686	7,730,635	0.022855	1,337,280	30,564	66.00
67.00	OCCUPATIONAL THERAPY	38,122	2,620,800	0.014546	421,968	6,138	67.00
68.00	SPEECH PATHOLOGY	12,601	1,507,648	0.008358	364,527	3,047	68.00
69.00	ELECTROCARDIOLOGY	850,406	53,600,311	0.015866	17,865,779	283,458	69.00
70.00	ELECTROENCEPHALOGRAPHY	34,788	2,636,151	0.013197	206,375	2,724	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	289,001	41,196,611	0.007015	11,244,293	78,879	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	377,154	28,800,953	0.013095	10,127,281	132,617	72.00
73.00	DRUGS CHARGED TO PATIENTS	620,301	93,923,884	0.006604	30,894,428	204,027	73.00
74.00	RENAL DIALYSIS	19,295	1,839,116	0.010491	1,343,487	14,095	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	25,023	709,074	0.035290	0	0	88.00
91.00	EMERGENCY	731,575	30,617,319	0.023894	4,584,871	109,551	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	349,415	11,117,100	0.031430	1,735,692	54,553	92.00
200.00	Total (lines 50-199)	9,093,709	532,707,928		134,809,416	1,990,956	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part III Date/Time Prepared: 4/2/2012 1:04 pm

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	ADULTS & PEDIATRICS	2,909,241	0	0	0	2,909,241	30.00
31.00	INTENSIVE CARE UNIT	339,933	0	0		339,933	31.00
40.00	SUBPROVIDER - IPF	254,803	0	0	0	254,803	40.00
41.00	SUBPROVIDER - IRF	20,842	0	0	0	20,842	41.00
43.00	NURSERY	54,160	0	0		54,160	43.00
44.00	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00	Total (lines 30-199)	3,578,979	0	0		3,578,979	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part III Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
		6.00	7.00	8.00	9.00	11.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	43,914	66.25	24,041	1,592,716	0	30.00
31.00	INTENSIVE CARE UNIT	5,488	61.94	2,819	174,609	0	31.00
40.00	SUBPROVIDER - IPF	9,347	27.26	1,507	41,081	0	40.00
41.00	SUBPROVIDER - IRF	4,835	4.31	3,196	13,775	0	41.00
43.00	NURSERY	2,450	22.11	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	5,896	0.00	4,882	0	0	44.00
200.00	Total (lines 30-199)	71,930		36,445	1,822,181	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part III Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
		12.00	13.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	0		30.00
31.00	INTENSIVE CARE UNIT	0	0		31.00
40.00	SUBPROVIDER - IPF	0	0		40.00
41.00	SUBPROVIDER - IRF	0	0		41.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	0	0		44.00
200.00	Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	163,068	0	0	163,068	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	158,224	0	0	158,224	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	300,063	0	300,063	54.00
60.00	LABORATORY	0	0	107,901	0	107,901	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	5,871	0	0	5,871	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	EMERGENCY	0	210,330	0	0	210,330	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	437,571	0	0	437,571	92.00
200.00	Total (lines 50-199)	0	975,064	407,964	0	1,383,028	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	163,068	61,723,717	0.002642	0.002642	11,018,555	50.00
52.00	DELIVERY ROOM & LABOR ROOM	158,224	3,757,744	0.042106	0.042106	12,343	52.00
53.00	ANESTHESIOLOGY	0	13,368,868	0.000000	0.000000	2,770,358	53.00
54.00	RADIOLOGY-DIAGNOSTIC	300,063	97,948,466	0.003063	0.003063	18,020,836	54.00
60.00	LABORATORY	107,901	67,518,407	0.001598	0.001598	16,989,565	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,484,114	0.000000	0.000000	2,148,808	62.00
65.00	RESPIRATORY THERAPY	0	7,607,010	0.000000	0.000000	3,722,970	65.00
66.00	PHYSICAL THERAPY	0	7,730,635	0.000000	0.000000	1,337,280	66.00
67.00	OCCUPATIONAL THERAPY	0	2,620,800	0.000000	0.000000	421,968	67.00
68.00	SPEECH PATHOLOGY	0	1,507,648	0.000000	0.000000	364,527	68.00
69.00	ELECTROCARDIOLOGY	5,871	53,600,311	0.000110	0.000110	17,865,779	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	2,636,151	0.000000	0.000000	206,375	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,196,611	0.000000	0.000000	11,244,293	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	28,800,953	0.000000	0.000000	10,127,281	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	93,923,884	0.000000	0.000000	30,894,428	73.00
74.00	RENAL DIALYSIS	0	1,839,116	0.000000	0.000000	1,343,487	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	709,074	0.000000	0.000000	0	88.00
91.00	EMERGENCY	210,330	30,617,319	0.006870	0.006870	4,584,871	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	437,571	11,117,100	0.039360	0.039360	1,735,692	92.00
200.00	Total (lines 50-199)	1,383,028	532,707,928			134,809,416	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	29,111	14,225,236	37,583	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	520	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	2,409,528	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	55,198	24,237,214	74,239	0	0	54.00
60.00	LABORATORY	27,149	1,187,821	1,898	0	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	531,390	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	1,101,813	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	623	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	1,965	11,776,640	1,295	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	836,480	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,721,442	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	4,863,501	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	13,741,209	0	0	0	73.00
74.00	RENAL DIALYSIS	0	234,060	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	EMERGENCY	31,498	4,614,438	31,701	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	68,317	4,294,747	169,041	0	0	92.00
200.00	Total (lines 50-199)	213,758	91,776,142	315,757	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	LABORATORY	0	0		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0		88.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part V Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.365299	14,225,236	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.713483	0	0	0		52.00
53.00	ANESTHESIOLOGY	0.049421	2,409,528	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.148390	24,237,214	0	0		54.00
60.00	LABORATORY	0.129812	1,187,821	0	0		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.418694	531,390	0	0		62.00
65.00	RESPIRATORY THERAPY	0.466034	1,101,813	0	0		65.00
66.00	PHYSICAL THERAPY	0.542664	0	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0.458023	623	0	0		67.00
68.00	SPEECH PATHOLOGY	0.278449	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	0.086763	11,776,640	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0.231380	836,480	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.229773	7,721,442	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.409102	4,863,501	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.196217	13,741,209	140,515	0		73.00
74.00	RENAL DIALYSIS	0.460567	234,060	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
91.00	EMERGENCY	0.338107	4,614,438	771	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.518491	4,294,747	0	0		92.00
200.00	Subtotal (see instructions)		91,776,142	141,286	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		91,776,142	141,286	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part V Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Costs: PPS Services (see instructions)	Costs: Cost Services Subject To Ded. & Coins. (see instructions)	Costs: Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	5,196,464	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	119,081	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	3,596,560	0	0		54.00
60.00	LABORATORY	154,193	0	0		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	222,490	0	0		62.00
65.00	RESPIRATORY THERAPY	513,482	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
67.00	OCCUPATIONAL THERAPY	285	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	1,021,777	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	193,545	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,774,179	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	1,989,668	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	2,696,259	27,571	0		73.00
74.00	RENAL DIALYSIS	107,800	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	EMERGENCY	1,560,174	261	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	2,226,788	0	0		92.00
200.00	Subtotal (see instructions)	21,372,745	27,832	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	21,372,745	27,832	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140015 | Component CCN: 14S015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part II | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,573,586	61,723,717	0.041695	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	147,095	3,757,744	0.039144	0	0	52.00
53.00	ANESTHESIOLOGY	106,930	13,368,868	0.007998	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,041,243	97,948,466	0.020840	45,956	958	54.00
60.00	LABORATORY	541,155	67,518,407	0.008015	297,220	2,382	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	45,075	4,484,114	0.010052	469	5	62.00
65.00	RESPIRATORY THERAPY	114,258	7,607,010	0.015020	1,253	19	65.00
66.00	PHYSICAL THERAPY	176,686	7,730,635	0.022855	762	17	66.00
67.00	OCCUPATIONAL THERAPY	38,122	2,620,800	0.014546	0	0	67.00
68.00	SPEECH PATHOLOGY	12,601	1,507,648	0.008358	0	0	68.00
69.00	ELECTROCARDIOLOGY	850,406	53,600,311	0.015866	28,033	445	69.00
70.00	ELECTROENCEPHALOGRAPHY	34,788	2,636,151	0.013197	708	9	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	289,001	41,196,611	0.007015	9,740	68	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	377,154	28,800,953	0.013095	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	620,301	93,923,884	0.006604	227,768	1,504	73.00
74.00	RENAL DIALYSIS	19,295	1,839,116	0.010491	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	25,023	709,074	0.035290	0	0	88.00
91.00	EMERGENCY	731,575	30,617,319	0.023894	99,910	2,387	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	349,415	11,117,100	0.031430	0	0	92.00
200.00	Total (lines 50-199)	9,093,709	532,707,928		711,819	7,794	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015 | Component CCN: 14S015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	163,068	0	0	163,068	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	158,224	0	0	158,224	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	300,063	0	300,063	54.00
60.00	LABORATORY	0	0	107,901	0	107,901	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	5,871	0	0	5,871	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	EMERGENCY	0	210,330	0	0	210,330	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	437,571	0	0	437,571	92.00
200.00	Total (lines 50-199)	0	975,064	407,964	0	1,383,028	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015 Component CCN: 14S015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	163,068	61,723,717	0.002642	0.002642	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	158,224	3,757,744	0.042106	0.042106	0	52.00
53.00	ANESTHESIOLOGY	0	13,368,868	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	300,063	97,948,466	0.003063	0.003063	45,956	54.00
60.00	LABORATORY	107,901	67,518,407	0.001598	0.001598	297,220	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,484,114	0.000000	0.000000	469	62.00
65.00	RESPIRATORY THERAPY	0	7,607,010	0.000000	0.000000	1,253	65.00
66.00	PHYSICAL THERAPY	0	7,730,635	0.000000	0.000000	762	66.00
67.00	OCCUPATIONAL THERAPY	0	2,620,800	0.000000	0.000000	0	67.00
68.00	SPEECH PATHOLOGY	0	1,507,648	0.000000	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	5,871	53,600,311	0.000110	0.000110	28,033	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	2,636,151	0.000000	0.000000	708	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,196,611	0.000000	0.000000	9,740	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	28,800,953	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	93,923,884	0.000000	0.000000	227,768	73.00
74.00	RENAL DIALYSIS	0	1,839,116	0.000000	0.000000	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	709,074	0.000000	0.000000	0	88.00
91.00	EMERGENCY	210,330	30,617,319	0.006870	0.006870	99,910	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	437,571	11,117,100	0.039360	0.039360	0	92.00
200.00	Total (lines 50-199)	1,383,028	532,707,928			711,819	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015 | Component CCN: 14S015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	141	0	0	0	0	54.00
60.00	LABORATORY	475	0	0	0	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	3	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	EMERGENCY	686	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	1,305	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015 | Component CCN: 14S015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	LABORATORY	0	0		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0		88.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140015 | Component CCN: 14T015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part II Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,573,586	61,723,717	0.041695	19,759	824	50.00
52.00	DELIVERY ROOM & LABOR ROOM	147,095	3,757,744	0.039144	0	0	52.00
53.00	ANESTHESIOLOGY	106,930	13,368,868	0.007998	1,596	13	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,041,243	97,948,466	0.020840	260,685	5,433	54.00
60.00	LABORATORY	541,155	67,518,407	0.008015	375,000	3,006	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	45,075	4,484,114	0.010052	26,525	267	62.00
65.00	RESPIRATORY THERAPY	114,258	7,607,010	0.015020	55,407	832	65.00
66.00	PHYSICAL THERAPY	176,686	7,730,635	0.022855	955,323	21,834	66.00
67.00	OCCUPATIONAL THERAPY	38,122	2,620,800	0.014546	712,890	10,370	67.00
68.00	SPEECH PATHOLOGY	12,601	1,507,648	0.008358	301,268	2,518	68.00
69.00	ELECTROCARDIOLOGY	850,406	53,600,311	0.015866	13,420	213	69.00
70.00	ELECTROENCEPHALOGRAPHY	34,788	2,636,151	0.013197	5,209	69	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	289,001	41,196,611	0.007015	87,033	611	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	377,154	28,800,953	0.013095	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	620,301	93,923,884	0.006604	771,861	5,097	73.00
74.00	RENAL DIALYSIS	19,295	1,839,116	0.010491	37,001	388	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	25,023	709,074	0.035290	0	0	88.00
91.00	EMERGENCY	731,575	30,617,319	0.023894	999	24	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	349,415	11,117,100	0.031430	0	0	92.00
200.00	Total (lines 50-199)	9,093,709	532,707,928		3,623,976	51,499	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015 Component CCN: 14T015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	163,068	0	0	163,068	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	158,224	0	0	158,224	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	300,063	0	300,063	54.00
60.00	LABORATORY	0	0	107,901	0	107,901	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	5,871	0	0	5,871	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	EMERGENCY	0	210,330	0	0	210,330	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	437,571	0	0	437,571	92.00
200.00	Total (lines 50-199)	0	975,064	407,964	0	1,383,028	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015 Component CCN: 14T015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	163,068	61,723,717	0.002642	0.002642	19,759	50.00
52.00	DELIVERY ROOM & LABOR ROOM	158,224	3,757,744	0.042106	0.042106	0	52.00
53.00	ANESTHESIOLOGY	0	13,368,868	0.000000	0.000000	1,596	53.00
54.00	RADIOLOGY-DIAGNOSTIC	300,063	97,948,466	0.003063	0.003063	260,685	54.00
60.00	LABORATORY	107,901	67,518,407	0.001598	0.001598	375,000	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,484,114	0.000000	0.000000	26,525	62.00
65.00	RESPIRATORY THERAPY	0	7,607,010	0.000000	0.000000	55,407	65.00
66.00	PHYSICAL THERAPY	0	7,730,635	0.000000	0.000000	955,323	66.00
67.00	OCCUPATIONAL THERAPY	0	2,620,800	0.000000	0.000000	712,890	67.00
68.00	SPEECH PATHOLOGY	0	1,507,648	0.000000	0.000000	301,268	68.00
69.00	ELECTROCARDIOLOGY	5,871	53,600,311	0.000110	0.000110	13,420	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	2,636,151	0.000000	0.000000	5,209	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,196,611	0.000000	0.000000	87,033	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	28,800,953	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	93,923,884	0.000000	0.000000	771,861	73.00
74.00	RENAL DIALYSIS	0	1,839,116	0.000000	0.000000	37,001	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	709,074	0.000000	0.000000	0	88.00
91.00	EMERGENCY	210,330	30,617,319	0.006870	0.006870	999	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	437,571	11,117,100	0.039360	0.039360	0	92.00
200.00	Total (lines 50-199)	1,383,028	532,707,928			3,623,976	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015 | Component CCN: 14T015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	52	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	798	0	0	0	0	54.00
60.00	LABORATORY	599	0	0	0	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	1	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	EMERGENCY	7	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	1,457	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015 | Component CCN: 14T015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	LABORATORY	0	0		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0		88.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015 Component CCN: 145643 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	163,068	0	0	163,068	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	158,224	0	0	158,224	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	300,063	0	300,063	54.00
60.00	LABORATORY	0	0	107,901	0	107,901	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	5,871	0	0	5,871	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	EMERGENCY	0	210,330	0	0	210,330	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	437,571	0	0	437,571	92.00
200.00	Total (lines 50-199)	0	975,064	407,964	0	1,383,028	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015 Component CCN: 145643 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	163,068	61,723,717	0.002642	0.002642	22,641	50.00
52.00	DELIVERY ROOM & LABOR ROOM	158,224	3,757,744	0.042106	0.042106	0	52.00
53.00	ANESTHESIOLOGY	0	13,368,868	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	300,063	97,948,466	0.003063	0.003063	156,104	54.00
60.00	LABORATORY	107,901	67,518,407	0.001598	0.001598	632,549	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,484,114	0.000000	0.000000	44,343	62.00
65.00	RESPIRATORY THERAPY	0	7,607,010	0.000000	0.000000	140,080	65.00
66.00	PHYSICAL THERAPY	0	7,730,635	0.000000	0.000000	857,392	66.00
67.00	OCCUPATIONAL THERAPY	0	2,620,800	0.000000	0.000000	407,102	67.00
68.00	SPEECH PATHOLOGY	0	1,507,648	0.000000	0.000000	66,803	68.00
69.00	ELECTROCARDIOLOGY	5,871	53,600,311	0.000110	0.000110	47,619	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	2,636,151	0.000000	0.000000	3,086	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,196,611	0.000000	0.000000	357,407	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	28,800,953	0.000000	0.000000	460	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	93,923,884	0.000000	0.000000	2,331,990	73.00
74.00	RENAL DIALYSIS	0	1,839,116	0.000000	0.000000	27,808	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	709,074	0.000000	0.000000	0	88.00
91.00	EMERGENCY	210,330	30,617,319	0.006870	0.006870	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	437,571	11,117,100	0.039360	0.039360	0	92.00
200.00	Total (lines 50-199)	1,383,028	532,707,928			5,095,384	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015 | Component CCN: 145643 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	60	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	478	0	0	0	0	54.00
60.00	LABORATORY	1,011	0	0	0	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	5	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	1,554	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015 | Component CCN: 145643 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	LABORATORY	0	0		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0		88.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-1 | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	43,914	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	43,914	2.00
3.00	Private room days (excluding swing-bed and observation bed days)	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	43,914	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)	24,041	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	38,323,212	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)	38,323,212	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	56,334,280	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	56,334,280	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.680282	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,282.83	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)	38,323,212	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	872.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	20,980,340	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)	20,980,340	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-1 | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	9,299,340	5,488	1,694.49	2,819	4,776,767	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)	30,200,564	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	55,957,671	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)	3,407,227	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,204,714	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	5,611,941	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	50,345,730	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)	6,605	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	872.69	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	5,764,117	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-1 | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,323,124	38,323,212	0.060619	5,764,117	349,415	90.00
91.00	Nursing School cost	2,909,241	38,323,212	0.075913	5,764,117	437,571	91.00
92.00	Allied health cost	0	38,323,212	0.000000	5,764,117	0	92.00
93.00	All other Medical Education	0	38,323,212	0.000000	5,764,117	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140015 Component CCN: 14S015	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1 Date/Time Prepared: 4/2/2012 1:04 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,347	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,347	2.00
3.00	Private room days (excluding swing-bed and observation bed days)	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	9,347	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)	1,507	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,144,022	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)	8,144,022	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	15,676,884	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	15,676,884	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.519492	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,677.21	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)	8,144,022	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	871.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,313,049	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)	1,313,049	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015 | Component CCN: 14S015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-1 | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	130,261	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,443,310	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)	99,070	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	9,099	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	108,169	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,335,141	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015 Component CCN: 14S015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-1 Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	359,694	8,144,022	0.044167	0	0	90.00
91.00	Nursing School cost	254,803	8,144,022	0.031287	0	0	91.00
92.00	Allied health cost	0	8,144,022	0.000000	0	0	92.00
93.00	All other Medical Education	0	8,144,022	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1 Date/Time Prepared: 4/2/2012 1:04 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,835	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,835	2.00
3.00	Private room days (excluding swing-bed and observation bed days)	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,835	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)	3,196	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,728,989	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)	3,728,989	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	4,621,844	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	4,621,844	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.806818	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)	955.91	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,728,989	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	771.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,464,915	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,464,915	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015 | Component CCN: 14T015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-1 | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,251,733	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,716,648	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)	154,751	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	52,956	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	207,707	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,508,941	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015 | Period: From 10/01/2010 | Worksheet D-1
Component CCN: 14T015 | To 09/30/2011 | Date/Time Prepared: 4/2/2012 1:04 pm
Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	213,284	3,728,989	0.057196	0	0	90.00
91.00	Nursing School cost	20,842	3,728,989	0.005589	0	0	91.00
92.00	Allied health cost	0	3,728,989	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,728,989	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1 Date/Time Prepared: 4/2/2012 1:04 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,896	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,896	2.00
3.00	Private room days (excluding swing-bed and observation bed days)	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,896	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)	4,882	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,835,956	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)	3,835,956	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	4,349,406	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	4,349,406	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.881949	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)	737.69	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,835,956	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015 | Component CCN: 145643 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-1 | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	3,835,956	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	650.60	71.00
72.00	Program routine service cost (line 9 x line 71)	3,176,229	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	3,176,229	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	3,176,229	83.00
84.00	Program inpatient ancillary services (see instructions)	1,425,273	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	4,601,502	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-1

Component CCN: 145643 | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	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: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-3 | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		35,461,450		30.00
31.00	INTENSIVE CARE UNIT		17,134,435		31.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.366560	11,018,555	4,038,962	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.713483	12,343	8,807	52.00
53.00	ANESTHESIOLOGY	0.049421	2,770,358	136,914	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.148390	18,020,836	2,674,112	54.00
60.00	LABORATORY	0.129812	16,989,565	2,205,449	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.418694	2,148,808	899,693	62.00
65.00	RESPIRATORY THERAPY	0.467419	3,722,970	1,740,187	65.00
66.00	PHYSICAL THERAPY	0.542664	1,337,280	725,694	66.00
67.00	OCCUPATIONAL THERAPY	0.458023	421,968	193,271	67.00
68.00	SPEECH PATHOLOGY	0.278449	364,527	101,502	68.00
69.00	ELECTROCARDIOLOGY	0.086989	17,865,779	1,554,126	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.233847	206,375	48,260	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.229773	11,244,293	2,583,635	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.409102	10,127,281	4,143,091	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.196217	30,894,428	6,062,012	73.00
74.00	RENAL DIALYSIS	0.460567	1,343,487	618,766	74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	EMERGENCY	0.341589	4,584,871	1,566,142	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.518491	1,735,692	899,941	92.00
200.00	Total (sum of lines 50-94 and 96-98)		134,809,416	30,200,564	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		134,809,416		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140015 | Component CCN: 14S015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-3 | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
40.00	SUBPROVIDER - IPF		2,507,866		40.00
41.00	SUBPROVIDER - IRF		0		41.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.366560	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.713483	0	0	52.00
53.00	ANESTHESIOLOGY	0.049421	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.148390	45,956	6,819	54.00
60.00	LABORATORY	0.129812	297,220	38,583	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.418694	469	196	62.00
65.00	RESPIRATORY THERAPY	0.467419	1,253	586	65.00
66.00	PHYSICAL THERAPY	0.542664	762	414	66.00
67.00	OCCUPATIONAL THERAPY	0.458023	0	0	67.00
68.00	SPEECH PATHOLOGY	0.278449	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.086989	28,033	2,439	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.233847	708	166	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.229773	9,740	2,238	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.409102	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.196217	227,768	44,692	73.00
74.00	RENAL DIALYSIS	0.460567	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	EMERGENCY	0.341589	99,910	34,128	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.518491	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		711,819	130,261	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		711,819		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-3

Component CCN: 14T015 | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		3,015,806		41.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.366560	19,759	7,243	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.713483	0	0	52.00
53.00	ANESTHESIOLOGY	0.049421	1,596	79	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.148390	260,685	38,683	54.00
60.00	LABORATORY	0.129812	375,000	48,680	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.418694	26,525	11,106	62.00
65.00	RESPIRATORY THERAPY	0.467419	55,407	25,898	65.00
66.00	PHYSICAL THERAPY	0.542664	955,323	518,419	66.00
67.00	OCCUPATIONAL THERAPY	0.458023	712,890	326,520	67.00
68.00	SPEECH PATHOLOGY	0.278449	301,268	83,888	68.00
69.00	ELECTROCARDIOLOGY	0.086989	13,420	1,167	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.233847	5,209	1,218	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.229773	87,033	19,998	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.409102	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.196217	771,861	151,452	73.00
74.00	RENAL DIALYSIS	0.460567	37,001	17,041	74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	EMERGENCY	0.341589	999	341	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.518491	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		3,623,976	1,251,733	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		3,623,976		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140015 | Component CCN: 145643 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-3 | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.365299	22,641	8,271	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.713483	0	0	52.00
53.00	ANESTHESIOLOGY	0.049421	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.148390	156,104	23,164	54.00
60.00	LABORATORY	0.129812	632,549	82,112	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.418694	44,343	18,566	62.00
65.00	RESPIRATORY THERAPY	0.466034	140,080	65,282	65.00
66.00	PHYSICAL THERAPY	0.542664	857,392	465,276	66.00
67.00	OCCUPATIONAL THERAPY	0.458023	407,102	186,462	67.00
68.00	SPEECH PATHOLOGY	0.278449	66,803	18,601	68.00
69.00	ELECTROCARDIOLOGY	0.086763	47,619	4,132	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.231380	3,086	714	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.229773	357,407	82,122	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.409102	460	188	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.196217	2,331,990	457,576	73.00
74.00	RENAL DIALYSIS	0.460567	27,808	12,807	74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	EMERGENCY	0.338107	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.518491	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		5,095,384	1,425,273	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		5,095,384		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet E Part A Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Hospital | PPS

		before 1/1	on/after 1/1	
		1.00	1.01	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS			
1.00	DRG Amounts Other than Outlier Payments	39,868,692		1.00
2.00	Outlier payments for discharges. (see instructions)	1,507,372		2.00
3.00	Managed Care Simulated Payments	739,156		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	170.90		4.00
	Indirect Medical Education Adjustment			
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	19.50		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)	19.50		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	17.04		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)	17.04		12.00
13.00	Total allowable FTE count for the prior year.	13.16		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.	13.16		14.00
15.00	Sum of lines 12 through 14 divided by 3.	14.45		15.00
16.00	Adjustment for residents in initial years of the program	0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure	0.00		17.00
18.00	Adjusted rolling average FTE count	14.45		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.084552		19.00
20.00	Prior year resident to bed ratio (see instructions)	0.069285		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.069285		21.00
22.00	IME payment adjustment (see instructions)	1,507,688		22.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA			
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000		26.00
27.00	IME payments adjustment. (see instructions)	0.000000		27.00
28.00	IME Adjustment (see instructions)	0		28.00
29.00	Total IME payment (sum of lines 22 and 28)	1,507,688		29.00
	Disproportionate Share Adjustment			
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.92		30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)	24.92		31.00
32.00	Sum of lines 30 and 31	28.84		32.00
33.00	Allowable disproportionate share percentage (see instructions)	11.50		33.00
34.00	Disproportionate share adjustment (see instructions)	4,584,900		34.00
	Additional payment for high percentage of ESRD beneficiary discharges			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 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)	47,468,652		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	48,853,921		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	48,853,921		49.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140015	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part A Date/Time Prepared: 4/2/2012 1:04 pm
	Title XVIII	Hospital	PPS

		before 1/1	on/after 1/1	
		1.00	1.01	
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	3,531,027		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).	585,350		52.00
53.00	Nursing and Allied Health Managed Care payment	22,251		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	1,767,325		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	213,758		58.00
59.00	Total (sum of amounts on lines 49 through 58)	54,973,632		59.00
60.00	Primary payer payments	57,494		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	54,916,138		61.00
62.00	Deductibles billed to program beneficiaries	4,538,494		62.00
63.00	Coinsurance billed to program beneficiaries	111,802		63.00
64.00	Allowable bad debts (see instructions)	802,980		64.00
65.00	Adjusted reimbursable bad debts (see instructions)	562,086		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	802,980		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	50,827,928		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	0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		70.00
70.95	Recovery of Accelerated Depreciation	0		70.95
70.96	Low Volume Payment-1	0		70.96
70.97	Low Volume Payment-2	0		70.97
70.98	Low Volume Payment-3	0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	50,827,928		71.00
72.00	Interim payments	50,376,750		72.00
73.00	Tentative settlement (for contractor use only)	0		73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)	451,178		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	54,052		75.00
	TO BE COMPLETED BY CONTRACTOR			
90.00	Operating outlier amount from Worksheet E, Part A line 2	0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2	0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)	0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)	0		93.00
94.00	The rate used to calculate the Time Value of Money	0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)	0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)	0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140015	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 4/2/2012 1:04 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	27,832	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	21,056,988	2.00
3.00	PPS payments	19,955,931	3.00
4.00	Outlier payment (see instructions)	108,928	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.897	5.00
6.00	Line 2 times line 5	18,888,118	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	315,757	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	27,832	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	9,466	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)	9,466	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	9,466	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	18,366	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	9,466	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)	20,380,616	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4,704,941	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)	15,685,141	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	191,262	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)	15,876,403	30.00
31.00	Primary payer payments	650	31.00
32.00	Subtotal (line 30 minus line 31)	15,875,753	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	734,325	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	514,028	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	734,325	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	16,389,781	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	16,389,781	40.00
41.00	Interim payments	16,957,755	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	-567,974	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140015	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 4/2/2012 1:04 pm
	Title XVIII	Hospital	PPS

		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	9,466	112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140015 Component CCN: 14S015	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 4/2/2012 1:04 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	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)	0	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)	0	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	0	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	0	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	0	40.00
41.00	Interim payments	0	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140015 Component CCN: 14S015	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 4/2/2012 1:04 pm
	Title XVIII	Subprovider - IPF	PPS

		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 4/2/2012 1:04 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	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)	0	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)	0	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	0	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	0	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	0	40.00
41.00	Interim payments	0	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 4/2/2012 1:04 pm
	Title XVIII	Subprovider - IRF	PPS

		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 4/2/2012 1:04 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		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)	0	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)	0	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	0	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	0	40.00
41.00	Interim payments	0	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 4/2/2012 1:04 pm
	Title XVIII	Skilled Nursing Facility	PPS

		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet E-1 Part I | Date/Time Prepared: 4/2/2012 1:04 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		50,857,026		16,700,744	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	06/03/2011	32,611	05/06/2011	107,238	3.01
3.02			0	06/03/2011	293,479	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	05/06/2011	298,522	09/16/2011	143,706	3.50
3.51		09/16/2011	214,365		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)		-480,276		257,011	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)		50,376,750		16,957,755	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		451,178		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		567,974	6.02
7.00	Total Medicare program liability (see instructions)		50,827,928		16,389,781	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet E-1 Part I | Date/Time Prepared: 4/2/2012 1:04 pm

Component CCN: 14S015 | Title XVIII | Subprovider - IPF | 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		1,032,633		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,032,633		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		42,386		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,075,019		0	7.00

			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140015 Component CCN: 14T015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet E-1 Part I Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Subprovider - IRF | 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		4,329,899		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	05/06/2011	16,264		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		16,264		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,346,163		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		73,474		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,419,637		0	7.00

			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2010 To 09/30/2011	Worksheet E-1 Part I Date/Time Prepared: 4/2/2012 1:04 pm
Title XVIII	Skilled Nursing Facility	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		1,718,559		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,718,559		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		1,554		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,720,113		0	7.00

			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140015	Period: From 10/01/2010 To 09/30/2011	Worksheet E-1 Part II Date/Time Prepared: 4/2/2012 1:04 pm
	Title XVIII	Hospital	PPS

		1.00	
	DATA COLLECTION NEEDED FOR THE HIT CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	11,057	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	26,860	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	384	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	42,797	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	648,052,562	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	48,204,804	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)	2,738,294	8.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment(s)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 minus line 30, plus or minus line 31)	2,738,294	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140015 Component CCN: 14S015	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part II Date/Time Prepared: 4/2/2012 1:04 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,191,994	1.00
2.00	Net IPF PPS Outlier Payments	5,210	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	25.608219	9.00
10.00	Medical Education Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,197,204	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition	0	14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,197,204	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,197,204	18.00
19.00	Deductibles	156,388	19.00
20.00	Subtotal (line 18 minus line 19)	1,040,816	20.00
21.00	Coinsurance	8,183	21.00
22.00	Subtotal (line 20 minus line 21)	1,032,633	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,032,633	26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	42,386	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,075,019	31.00
32.00	Interim payments	1,032,633	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)	42,386	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	1,166	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part III Date/Time Prepared: 4/2/2012 1:04 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	4,198,043	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0219	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	229,918	3.00
4.00	Outlier Payments	14,238	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	13.246575	10.00
11.00	Medical Education Adjustment Factor {((1 + (line 9/line 10)) raised to the power of .6876 -1}.	0.000000	11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).	0	12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)	4,442,199	13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)	0	14.00
15.00	Organ acquisition	0	15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	16.00
17.00	Subtotal (see instructions)	4,442,199	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	4,442,199	19.00
20.00	Deductibles	19,116	20.00
21.00	Subtotal (line 19 minus line 20)	4,423,083	21.00
22.00	Coinsurance	18,678	22.00
23.00	Subtotal (line 21 minus line 22)	4,404,405	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	4,404,405	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	15,232	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	4,419,637	32.00
33.00	Interim payments	4,346,163	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus the sum lines 33 and 34)	73,474	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	425	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part III, line 4	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part VI Date/Time Prepared: 4/2/2012 1:04 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,829,789	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	1,554	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,831,343	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	111,230	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Allowable reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	1,720,113	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	1,720,113	15.00
16.00	Interim payments	1,718,559	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)	1,554	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	42	19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet E-4 | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			19.50	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 plus line 4.02 plus applicable subscripts			19.50	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			17.83	6.00
7.00	Enter the lesser of line 5 or line 6			17.83	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	17.83	0.00	17.83	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	17.83	0.00	17.83	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	17.83	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	17.61	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	19.33	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	18.26	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	18.26	0.00		17.00
18.00	Per resident amount	75,984.71	0.00		18.00
19.00	Approved amount for resident costs	1,387,481	0	1,387,481	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	GME FTE weighted Resident count over Cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,387,481	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days	31,563	384		26.00
27.00	Total Inpatient Days	56,979	56,979		27.00
28.00	Ratio of inpatient days to total inpatient days	0.553941	0.006739		28.00
29.00	Program direct GME amount	768,583	9,350		29.00
30.00	Reduction for nursing/allied health		1,321		30.00
31.00	Net Program direct GME amount			776,612	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 140015	Period: From 10/01/2010 To 09/30/2011	Worksheet E-4 Date/Time Prepared: 4/2/2012 1:04 pm
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Worksheet C, Part I, column 8, sum of lines 74 and 94)	1,839,116	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	66,125,201	37.00
38.00	Organ acquisition costs (Worksheet D-4, Part III, column 1, line 69)	0	38.00
39.00	Cost of teaching physicians (Worksheet D-5, Part II, column 3, line 20)	0	39.00
40.00	Primary payer payments (see instructions)	57,494	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	66,067,707	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	21,588,042	42.00
43.00	Primary payer payments (see instructions)	650	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	21,587,392	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	87,655,099	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.753723	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.246277	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	776,612	48.00
49.00	Part A Medicare GME payment (line 46 x 48)(Title XVIII only)(see instructions)	585,350	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	191,262	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet G | Date/Time Prepared: 4/2/2012 1:04 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURENT ASSETS					
1.00	Cash on hand in banks	58,182,321	0	0	0	1.00
2.00	Temporary investments	69,610,225	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	140,413,070	0	0	0	4.00
5.00	Other receivable	7,329,539	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-83,366,501	0	0	0	6.00
7.00	Inventory	5,660,877	0	0	0	7.00
8.00	Prepaid expenses	3,598,118	0	0	0	8.00
9.00	Other current assets	199,683	0	0	0	9.00
10.00	Due from other funds	2,696,566	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	204,323,898	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	12,458,356	0	0	0	12.00
13.00	Land improvements	5,697,771	0	0	0	13.00
14.00	Accumulated depreciation	-4,336,351	0	0	0	14.00
15.00	Buildings	138,761,418	0	0	0	15.00
16.00	Accumulated depreciation	-55,714,809	0	0	0	16.00
17.00	Leasehold improvements	1,301,450	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	-27,569,050	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	122,766,017	0	0	0	23.00
24.00	Accumulated depreciation	-90,793,926	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	102,570,876	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	12,595,337	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	10,073,792	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	22,669,129	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	329,563,903	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	12,210,599	0	0	0	37.00
38.00	Salaries, wages, and fees payable	15,810,659	0	0	0	38.00
39.00	Payroll taxes payable	1,531,504	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,560,000	0	0	0	40.00
41.00	Deferred income	1,137,092	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	9,646,380	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	43,896,234	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	78,877,801	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	72,964,527	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	151,842,328	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	195,738,562	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	133,825,341				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	133,825,341	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	329,563,903	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet G-1 | Date/Time Prepared: 4/2/2012 1:04 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		126,560,995		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		16,339,213				2.00
3.00	Total (sum of line 1 and line 2)		142,900,208		0		3.00
4.00	CONTRIBUTIONS	1,997,552		0			4.00
5.00		0		0			5.00
6.00		0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		1,997,552		0		10.00
11.00	Subtotal (line 3 plus line 10)		144,897,760		0		11.00
12.00	MINIMUM PENSION LIABILITY	9,308,247		0			12.00
13.00	NER REAL AND UNREAL GAINS	7,472		0			13.00
14.00	NET ASSETS RELEASED FROM RESTRICTION	1,747,736		0			14.00
15.00	OTHER	8,964		0			15.00
16.00		0		0			16.00
17.00		0		0			17.00
18.00	Total deductions (sum of lines 12-17)		11,072,419		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		133,825,341		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet G-1 | Date/Time Prepared: 4/2/2012 1:04 pm

		Endowment Fund		Plant Fund			
		5.00	6.00	7.00	8.00		
1.00	Fund balances at beginning of period		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)		0		0		3.00
4.00	CONTRIBUTIONS	0		0			4.00
5.00		0		0			5.00
6.00		0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		0		0		11.00
12.00	MINIMUM PENSION LIABILITY	0		0			12.00
13.00	NER REAL AND UNREAL GAINS	0		0			13.00
14.00	NET ASSETS RELEASED FROM RESTRICTION	0		0			14.00
15.00	OTHER	0		0			15.00
16.00		0		0			16.00
17.00		0		0			17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet G-2 Parts | Date/Time Prepared: 4/2/2012 1:04 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	56,334,280		56,334,280	1.00
2.00	SUBPROVIDER - IPF	15,676,884		15,676,884	2.00
3.00	SUBPROVIDER - IRF	4,621,844		4,621,844	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	4,349,406		4,349,406	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)	80,982,414		80,982,414	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	29,173,776		29,173,776	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)	29,173,776		29,173,776	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	110,156,190		110,156,190	17.00
18.00	Ancillary services	244,003,142	352,156,009	596,159,151	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	709,074	709,074	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,505,466	2,505,466	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	3,569,186	3,569,186	26.00
27.00	NURSERY	2,068,548	0	2,068,548	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	356,227,880	358,939,735	715,167,615	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		263,727,756		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)		263,727,756		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet G-3 | Date/Time Prepared: 4/2/2012 1:04 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	715,167,615	1.00
2.00	Less contractual allowances and discounts on patients' accounts	452,005,001	2.00
3.00	Net patient revenues (line 1 minus line 2)	263,162,614	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	263,727,756	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-565,142	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-35,799	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	496,057	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	1,491,373	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	52,310	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	2,747,485	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	1,054,701	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	9,363,709	24.00
24.01	TRANSFERS	1,136,455	24.01
24.02	TRANSFERS	598,064	24.02
25.00	Total other income (sum of lines 6-24)	16,904,355	25.00
26.00	Total (line 5 plus line 25)	16,339,213	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)	16,339,213	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140015 HHA CCN: 147031 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H | Date/Time Prepared: 4/2/2012 1:04 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures			0		0	1.00
2.00	Capital Related - Movable Equipment			0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	252,311	0	0	0	0	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	901,244	0	69,989	0	109,885	6.00
7.00	Physical Therapy	227,308	0	17,333	0	27,213	7.00
8.00	Occupational Therapy	57,660	0	4,392	0	6,895	8.00
9.00	Speech Pathology	7,127	0	548	0	860	9.00
10.00	Medical Social Services	8,018	0	22	0	35	10.00
11.00	Home Health Aide	96,159	0	19,467	0	30,564	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	16,252	0	0	0	123,409	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,566,079	0	111,751	0	298,861	24.00

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

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140015 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H

HHA CCN: 147031 | Date/Time Prepared: 4/2/2012 1:04 pm

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		Total (sum of cols. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	252,311	0	252,311	0	252,311	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	1,081,118	-3,357	1,077,761	0	1,077,761	6.00
7.00	Physical Therapy	271,854	-271,854	0	0	0	7.00
8.00	Occupational Therapy	68,947	-68,947	0	0	0	8.00
9.00	Speech Pathology	8,535	-8,535	0	0	0	9.00
10.00	Medical Social Services	8,075	0	8,075	0	8,075	10.00
11.00	Home Health Aide	146,190	0	146,190	0	146,190	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	139,661	0	139,661	0	139,661	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,976,691	-352,693	1,623,998	0	1,623,998	24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 140015 HHA CCN: 147031

Period: From 10/01/2010 To 09/30/2011

Worksheet H-1 Part I Date/Time Prepared: 4/2/2012 1:04 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
			Bldgs & Fixtures	Movable Equipment			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0				1.00
2.00	Capital Related - Movable Equipment	0		0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	252,311	0	0	0	0	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	1,077,761	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	8,075	0	0	0	0	10.00
11.00	Home Health Aide	146,190	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	139,661	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)	1,623,998	0	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 140015 HHA CCN: 147031

Period: From 10/01/2010 To 09/30/2011

Worksheet H-1 Part I Date/Time Prepared: 4/2/2012 1:04 pm

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		Subtotal (cols. 0-4)	Administrative & General	Total (cols. 4A + 5)		
		4A.00	5.00	6.00		
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0				1.00
2.00	Capital Related - Movable Equipment	0				2.00
3.00	Plant Operation & Maintenance	0				3.00
4.00	Transportation					4.00
5.00	Administrative and General	252,311	252,311			5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	1,077,761	198,246	1,276,007		6.00
7.00	Physical Therapy	0	0	0		7.00
8.00	Occupational Therapy	0	0	0		8.00
9.00	Speech Pathology	0	0	0		9.00
10.00	Medical Social Services	8,075	1,485	9,560		10.00
11.00	Home Health Aide	146,190	26,890	173,080		11.00
12.00	Supplies (see instructions)	0	0	0		12.00
13.00	Drugs	0	0	0		13.00
14.00	DME	0	0	0		14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0		17.00
18.00	Clinic	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0		19.00
20.00	Day Care Program	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0		21.00
22.00	Homemaker Service	139,661	25,690	165,351		22.00
23.00	All Others (specify)	0	0	0		23.00
24.00	Total (sum of lines 1-23)	1,371,687		1,623,998		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 140015 | HHA CCN: 147031 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-1 Part II | Date/Time Prepared: 4/2/2012 1:04 pm

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		Capital Related Costs					
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		1.00	2.00	3.00	4.00	5A.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-252,311	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-252,311	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 140015 HHA CCN: 147031

Period: From 10/01/2010 To 09/30/2011

Worksheet H-1 Part II Date/Time Prepared: 4/2/2012 1:04 pm

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		Administrative & General (ACCUM. COST)		
		5.00		
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation (see instructions)			4.00
5.00	Administrative and General	1,371,687		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	1,077,761		6.00
7.00	Physical Therapy	0		7.00
8.00	Occupational Therapy	0		8.00
9.00	Speech Pathology	0		9.00
10.00	Medical Social Services	8,075		10.00
11.00	Home Health Aide	146,190		11.00
12.00	Supplies (see instructions)	0		12.00
13.00	Drugs	0		13.00
14.00	DME	0		14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0		15.00
16.00	Respiratory Therapy	0		16.00
17.00	Private Duty Nursing	0		17.00
18.00	Clinic	0		18.00
19.00	Health Promotion Activities	0		19.00
20.00	Day Care Program	0		20.00
21.00	Home Delivered Meals Program	0		21.00
22.00	Homemaker Service	139,661		22.00
23.00	All Others (specify)	0		23.00
24.00	Total (sum of lines 1-23)	1,371,687		24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	252,311		25.00
26.00	Unit Cost Multiplier	0.183942		26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140015 HHA CCN: 147031 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-2 Part I Date/Time Prepared: 4/2/2012 1:04 pm

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			CAPITAL RELATED COSTS				
		HHA Trial Balance (1)	BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT	
		0	1.00	1.01	1.02	1.03	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	1,276,007	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	9,560	0	0	0	0	6.00
7.00	Home Health Aide	173,080	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	165,351	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	1,623,998	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140015 HHA CCN: 147031 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-2 Part I Date/Time Prepared: 4/2/2012 1:04 pm

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		CAPITAL RELATED COSTS					
		14TH STREET	MOB PHASE I	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		1.04	1.05	2.00	4.00	4A	
1.00	Administrative and General	1,660	0	15,100	61,882	78,642	1.00
2.00	Skilled Nursing Care	0	0	0	220,366	1,496,373	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	1,967	11,527	6.00
7.00	Home Health Aide	0	0	0	23,584	196,664	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	3,986	169,337	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	1,660	0	15,100	311,785	1,952,543	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000	21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140015 HHA CCN: 147031 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-2 Part I Date/Time Prepared: 4/2/2012 1:04 pm

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		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
1.00	Administrative and General	19,834	83,822	0	179,096	0	1.00
2.00	Skilled Nursing Care	377,388	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	2,907	0	0	0	0	6.00
7.00	Home Health Aide	49,599	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	42,707	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	492,435	83,822	0	179,096	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: 140015 HHA CCN: 147031

Period: From 10/01/2010 To 09/30/2011

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		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL		
		11.00	13.00	16.00	20.00		
1.00	Administrative and General	61,248	293,404	0	0		1.00
2.00	Skilled Nursing Care	0	0	0	0		2.00
3.00	Physical Therapy	0	0	0	0		3.00
4.00	Occupational Therapy	0	0	0	0		4.00
5.00	Speech Pathology	0	0	0	0		5.00
6.00	Medical Social Services	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0	0		8.00
9.00	Drugs	0	0	0	0		9.00
10.00	DME	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0		13.00
14.00	Clinic	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0		19.00
20.00	Total (sum of lines 1-19) (2)	61,248	293,404	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: 140015 HHA CCN: 147031

Period: From 10/01/2010 To 09/30/2011

Worksheet H-2 Part I Date/Time Prepared: 4/2/2012 1:04 pm

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		INTERNS & RESIDENTS					
		SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
		21.00	22.00	23.00	23.01	23.02	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140015 HHA CCN: 147031

Period: From 10/01/2010 To 09/30/2011

Worksheet H-2 Part I Date/Time Prepared: 4/2/2012 1:04 pm

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		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	716,046	0	716,046			1.00
2.00	Skilled Nursing Care	1,873,761	0	1,873,761	571,787	2,445,548	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	14,434	0	14,434	4,405	18,839	6.00
7.00	Home Health Aide	246,263	0	246,263	75,148	321,411	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	212,044	0	212,044	64,706	276,750	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	3,062,548	0	3,062,548	716,046	3,062,548	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.				0.305155		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: 140015 HHA CCN: 147031

Period: From 10/01/2010 To 09/30/2011

Worksheet H-2 Part II Date/Time Prepared: 4/2/2012 1:04 pm

Home Health Agency I

PPS

		CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BUILDING & FIXT (SQUARE FEET)	NEW BUILDING & FIXT (SQUARE FEET)	14TH STREET (SQUARE FEET)	
		1.00	1.01	1.02	1.03	1.04	
1.00	Administrative and General	0	0	0	0	4,925	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	0	0	4,925	20.00
21.00	Total cost to be allocated	0	0	0	0	1,660	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.337056	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140015 HHA CCN: 147031

Period: From 10/01/2010 To 09/30/2011

Worksheet H-2 Part II Date/Time Prepared: 4/2/2012 1:04 pm

Home Health Agency I

PPS

		CAPITAL RELATED COSTS					
		MOB PHASE I (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.05	2.00	4.00	5A	5.00	
1.00	Administrative and General	0	15,216	252,311	0	78,642	1.00
2.00	Skilled Nursing Care	0	0	898,493	0	1,496,373	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	8,018	0	11,527	6.00
7.00	Home Health Aide	0	0	96,159	0	196,664	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	16,252	0	169,337	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	15,216	1,271,233		1,952,543	20.00
21.00	Total cost to be allocated	0	15,100	311,785		492,435	21.00
22.00	Unit cost multiplier	0.000000	0.992376	0.245262		0.252202	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140015 HHA CCN: 147031

Period: From 10/01/2010 To 09/30/2011

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		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		6.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	4,925	0	5,175	0	7,170	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	4,925	0	5,175	0	7,170	20.00
21.00	Total cost to be allocated	83,822	0	179,096	0	61,248	21.00
22.00	Unit cost multiplier	17.019695	0.000000	34.607923	0.000000	8.542259	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140015 HHA CCN: 147031 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-2 Part II Date/Time Prepared: 4/2/2012 1:04 pm

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		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	
		13.00	16.00	20.00	21.00	22.00	
1.00	Administrative and General	51,422	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	51,422	0	0	0	0	20.00
21.00	Total cost to be allocated	293,404	0	0	0	0	21.00
22.00	Unit cost multiplier	5.705807	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140015 HHA CCN: 147031

Period: From 10/01/2010 To 09/30/2011

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		PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)		
		23.00	23.01	23.02		
1.00	Administrative and General	0	0	0		1.00
2.00	Skilled Nursing Care	0	0	0		2.00
3.00	Physical Therapy	0	0	0		3.00
4.00	Occupational Therapy	0	0	0		4.00
5.00	Speech Pathology	0	0	0		5.00
6.00	Medical Social Services	0	0	0		6.00
7.00	Home Health Aide	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0		8.00
9.00	Drugs	0	0	0		9.00
10.00	DME	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0		13.00
14.00	Clinic	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0		15.00
16.00	Day Care Program	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0		17.00
18.00	Homemaker Service	0	0	0		18.00
19.00	All Others (specify)	0	0	0		19.00
20.00	Total (sum of lines 1-19)	0	0	0		20.00
21.00	Total cost to be allocated	0	0	0		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140015 | HHA CCN: 147031 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-3 Parts I-II | Date/Time Prepared: 4/2/2012 1:04 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	2.00	2,445,548		2,445,548	14,262	1.00
2.00	Physical Therapy	3.00	0	281,833	281,833	3,533	2.00
3.00	Occupational Therapy	4.00	0	60,327	60,327	896	3.00
4.00	Speech Pathology	5.00	0	4,543	4,543	111	4.00
5.00	Medical Social Services	6.00	18,839		18,839	4	5.00
6.00	Home Health Aide	7.00	321,411		321,411	3,966	6.00
7.00	Total (sum of lines 1-6)		2,785,798	346,703	3,132,501	22,772	7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
	Limitation Cost Computation						
8.00	Skilled Nursing Care		99914	3,570	3,113		8.00
8.01	Skilled Nursing Care		99926	194	98		8.01
9.00	Physical Therapy		99914	1,314	728		9.00
9.01	Physical Therapy		99926	53	21		9.01
10.00	Occupational Therapy		99914	310	174		10.00
10.01	Occupational Therapy		99926	15	0		10.01
11.00	Speech Pathology		99914	85	11		11.00
11.01	Speech Pathology		99926	10	0		11.01
12.00	Medical Social Services		99914	1	2		12.00
12.01	Medical Social Services		99926	0	0		12.01
13.00	Home Health Aide		99914	567	1,610		13.00
13.01	Home Health Aide		99926	6	426		13.01
14.00	Total (sum of lines 8-13)			6,125	6,183		14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
	Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	8.00	0	0	0	26,014	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	
		0	1.00	2.00	3.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS					
1.00	Physical Therapy	66.00	0.542664	519,351	281,833	1.00
2.00	Occupational Therapy	67.00	0.458023	131,712	60,327	2.00
3.00	Speech Pathology	68.00	0.278449	16,317	4,543	3.00
4.00	Cost of Medical Supplies	71.00	0.229773	0	0	4.00
5.00	Cost of Drugs	73.00	0.196217	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140015 HHA CCN: 147031 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-3 Parts I-II Date/Time Prepared: 4/2/2012 1:04 pm

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	Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	171.47	3,764	3,211			1.00
2.00	Physical Therapy	79.77	1,367	749			2.00
3.00	Occupational Therapy	67.33	325	174			3.00
4.00	Speech Pathology	40.93	95	11			4.00
5.00	Medical Social Services	4,709.75	1	2			5.00
6.00	Home Health Aide	81.04	573	2,036			6.00
7.00	Total (sum of lines 1-6)		6,125	6,183			7.00

	Cost Center Description	Ratio (col. 3 ÷ col. 4)	Program Covered Charges: Part A	Program Covered Charges: Part B Not Subject to Deductibles & Coinsurance	Program Covered Charges: Part B Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00	9.00	
	Limitation Cost Computation						
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
14.00	Total (sum of lines 8-13)						14.00

	Cost Center Description	Ratio (col. 3 ÷ col. 4)	Program Covered Charges: Part A	Program Covered Charges: Part B Not Subject to Deductibles & Coinsurance	Program Covered Charges: Part B Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00		
	Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0.000000	10,087	15,927	0		15.00
16.00	Cost of Drugs	0.000000	0	0	0		16.00

	Cost Center Description	Transfer to Part I as Indicated	
		4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS		
1.00	Physical Therapy	col. 2, line 2.00	1.00
2.00	Occupational Therapy	col. 2, line 3.00	2.00
3.00	Speech Pathology	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	col. 2, line 15.00	4.00
5.00	Cost of Drugs	col. 2, line 16.00	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140015 HHA CCN: 147031 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-3 Parts I-II Date/Time Prepared: 4/2/2012 1:04 pm

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	Cost Center Description	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols. 9-10)		
		9.00	10.00	11.00	12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	645,413	550,590		1,196,003		1.00
2.00	Physical Therapy	109,046	59,748		168,794		2.00
3.00	Occupational Therapy	21,882	11,715		33,597		3.00
4.00	Speech Pathology	3,888	450		4,338		4.00
5.00	Medical Social Services	4,710	9,420		14,130		5.00
6.00	Home Health Aide	46,436	164,997		211,433		6.00
7.00	Total (sum of lines 1-6)	831,375	796,920		1,628,295		7.00
	Cost Center Description						
		10.00	11.00	12.00			
	Limitation Cost Computation						
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
14.00	Total (sum of lines 8-13)						14.00

	Cost Center Description	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance		
		9.00	10.00	11.00		
	Supplies and Drugs Cost Computations					
15.00	Cost of Medical Supplies	0	0	0		15.00
16.00	Cost of Drugs	0	0	0		16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140015 | Period: From 10/01/2010 | Worksheet H-4 Part I-II
HHA CCN: 147031 | To 09/30/2011 | Date/Time Prepared: 4/2/2012 1:04 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	863,130	776,561	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	863,130	776,561	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	863,130	776,561	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	842,606	507,456	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	38,778	79,183	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	13,852	13,158	13.00
14.00	Total PPS Reimbursement - PEP Episodes	7,373	2,780	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	22,158	42,731	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	924,767	645,308	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	924,767	645,308	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	924,767	645,308	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	924,767	645,308	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	924,767	645,308	31.00
32.00	Interim payments (see instructions)	924,767	645,308	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	35.00

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

Provider CCN: 140015 HHA CCN: 147031 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-5 | Date/Time Prepared: 4/2/2012 1:04 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		924,767		645,308	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)		924,767		645,308	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		924,767		645,308	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140015 Hospice CCN: 141501 | Period: From 10/01/2010 To 09/30/2011 | Worksheet K | Date/Time Prepared: 4/2/2012 1:04 pm

Hospice I

		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	377,878	0	107,451	0	187,323	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	27,717	0	0	51,000	0	9.00
10.00	Nursing Care	900,155	0	0	49,110	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	167,118	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	99,303	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	142,847	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	35,250	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,572,171	0	107,451	100,110	365,420	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140015 Hospice CCN: 141501 | Period: From 10/01/2010 To 09/30/2011 | Worksheet K | Date/Time Prepared: 4/2/2012 1:04 pm

Hospice I

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	672,652	0	672,652	0	672,652	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	78,717	0	78,717	-27,379	51,338	9.00
10.00	Nursing Care	949,265	-914	948,351	0	948,351	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	167,118	0	167,118	0	167,118	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	99,303	0	99,303	0	99,303	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	142,847	0	142,847	0	142,847	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	35,250	-189	35,061	0	35,061	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	2,145,152	-1,103	2,144,049	-27,379	2,116,670	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140015 Hospice CCN: 141501 | Period: From 10/01/2010 To 09/30/2011 | Worksheet K-1 | Date/Time Prepared: 4/2/2012 1:04 pm

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	900,155	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	167,118	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	167,118	0	900,155	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140015 Hospice CCN: 141501

Period: From 10/01/2010 To 09/30/2011

Worksheet K-1

Date/Time Prepared: 4/2/2012 1:04 pm

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	377,878	377,878		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	27,717	27,717		9.00
10.00	Nursing Care		0	0	900,155		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	167,118		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		99,303	0	99,303		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	99,303	405,595	1,572,171		39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 140015 Hospice CCN: 141501 | Period: From 10/01/2010 To 09/30/2011 | Worksheet K-3 Date/Time Prepared: 4/2/2012 1:04 pm

Hospice I

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

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 140015 Hospice CCN: 141501 | Period: From 10/01/2010 To 09/30/2011 | Worksheet K-3 | Date/Time Prepared: 4/2/2012 1:04 pm

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	51,000	51,000		9.00
10.00	Nursing Care		49,110	0	49,110		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	49,110	51,000	100,110		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140015 Hospice CCN: 141501

Period: From 10/01/2010 To 09/30/2011

Worksheet K-4 Part I Date/Time Prepared: 4/2/2012 1:04 pm

Hospice I

			CAPITAL RELATED COST				
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	672,652	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	51,338	0	0	0	0	9.00
10.00	Nursing Care	948,351	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	167,118	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	99,303	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	142,847	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	35,061	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	2,116,670	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140015 Hospice CCN: 141501

Period: From 10/01/2010 To 09/30/2011

Worksheet K-4 Part I Date/Time Prepared: 4/2/2012 1:04 pm

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.		0				1.00
2.00	Capital Related Costs-Movable Equip.		0				2.00
3.00	Plant Operation and Maintenance		0				3.00
4.00	Transportation - Staff		0				4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	672,652				6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0		7.00
8.00	Inpatient - Respite Care	0	0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services	0	51,338	23,914	75,252		9.00
10.00	Nursing Care	0	948,351	441,761	1,390,112		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	167,118	77,847	244,965		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	99,303	46,257	145,560		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		20.00
21.00	Other	0	0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	142,847	66,541	209,388		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	35,061	16,332	51,393		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0		31.00
32.00	Radiation Therapy	0	0	0	0		32.00
33.00	Chemotherapy	0	0	0	0		33.00
34.00	Other	0	0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0		35.00
36.00	Volunteer Program Costs	0	0	0	0		36.00
37.00	Fundraising	0	0	0	0		37.00
38.00	Other Program Costs	0	0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	1,444,018	672,652	2,116,670		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140015 Hospice CCN: 141501 | Period: From 10/01/2010 To 09/30/2011 | Worksheet K-4 Part II Date/Time Prepared: 4/2/2012 1:04 pm

Hospice I

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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140015 Hospice CCN: 141501 | Period: From 10/01/2010 To 09/30/2011 | Worksheet K-4 Part II Date/Time Prepared: 4/2/2012 1:04 pm

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)		
		6A	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0			1.00
2.00	Capital Related Costs-Movable Equip.	0			2.00
3.00	Plant Operation and Maintenance	0			3.00
4.00	Transportation - Staff	0			4.00
5.00	Volunteer Service Coordination				5.00
6.00	Administrative and General	-672,652	1,444,018		6.00
	INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0		7.00
8.00	Inpatient - Respite Care	0	0		8.00
	VISITING SERVICES				
9.00	Physician Services	0	51,338		9.00
10.00	Nursing Care	0	948,351		10.00
11.00	Nursing Care-Continuous Home Care	0	0		11.00
12.00	Physical Therapy	0	0		12.00
13.00	Occupational Therapy	0	0		13.00
14.00	Speech/ Language Pathology	0	0		14.00
15.00	Medical Social Services	0	167,118		15.00
16.00	Spiritual Counseling	0	0		16.00
17.00	Dietary Counseling	0	0		17.00
18.00	Counseling - Other	0	0		18.00
19.00	Home Health Aide and Homemaker	0	99,303		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		20.00
21.00	Other	0	0		21.00
	OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	142,847		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	35,061		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		31.00
32.00	Radiation Therapy	0	0		32.00
33.00	Chemotherapy	0	0		33.00
34.00	Other	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0		35.00
36.00	Volunteer Program Costs	0	0		36.00
37.00	Fundraising	0	0		37.00
38.00	Other Program Costs	0	0		38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		672,652		39.00
40.00	Unit Cost Multiplier		0.465820		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015 Hospice CCN: 141501

Period: From 10/01/2010 To 09/30/2011

Worksheet K-5 Part I Date/Time Prepared: 4/2/2012 1:04 pm

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS				
			BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT	
		0	1.00	1.01	1.02	1.03	
1.00	Administrative and General		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	75,252	0	0	0	0	4.00
5.00	Nursing Care	1,390,112	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	244,965	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	145,560	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	209,388	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	51,393	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)	2,116,670	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: 140015 Hospice CCN: 141501

Period: From 10/01/2010 To 09/30/2011

Worksheet K-5 Part I Date/Time Prepared: 4/2/2012 1:04 pm

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		14TH STREET	MOB PHASE I	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		1.04	1.05	2.00	4.00	4A	
1.00	Administrative and General	2,609	0	23,336	92,679	118,624	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	83	75,335	4.00
5.00	Nursing Care	0	0	0	220,550	1,610,662	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	40,988	285,953	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	24,355	169,915	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	209,388	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	51,393	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)	2,609	0	23,336	378,655	2,521,270	34.00
35.00	Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015 Hospice CCN: 141501

Period: From 10/01/2010 To 09/30/2011

Worksheet K-5 Part I Date/Time Prepared: 4/2/2012 1:04 pm

Hospice I

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
1.00	Administrative and General	29,917	131,783	1,668	22,426	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	19,000	0	0	0	0	4.00
5.00	Nursing Care	406,212	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	72,118	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	42,853	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	52,808	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	12,961	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)	635,869	131,783	1,668	22,426	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2010
To 09/30/2011

Worksheet K-5
Part I
Date/Time Prepared:
4/2/2012 1:04 pm

Hospice I

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL		
		11.00	13.00	16.00	20.00		
1.00	Administrative and General	78,316	375,134	0	5,871		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)	78,316	375,134	0	5,871		34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015 Hospice CCN: 141501

Period: From 10/01/2010 To 09/30/2011

Worksheet K-5 Part I Date/Time Prepared: 4/2/2012 1:04 pm

Hospice I

	Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
		21.00	22.00	23.00	23.01	23.02	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015 Hospice CCN: 141501

Period: From 10/01/2010 To 09/30/2011

Worksheet K-5 Part I Date/Time Prepared: 4/2/2012 1:04 pm

Hospice I

	Cost Center Description	Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	763,739					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	94,335	0	94,335	23,947	118,282	4.00
5.00	Nursing Care	2,016,874	0	2,016,874	511,988	2,528,862	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	358,071	0	358,071	90,897	448,968	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	212,768	0	212,768	54,012	266,780	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	262,196	0	262,196	66,559	328,755	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	64,354	0	64,354	16,336	80,690	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)	3,772,337	0	3,772,337		3,772,337	34.00
35.00	Unit Cost Multiplier (see instructions)				0.253852		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2010
To 09/30/2011

Worksheet K-5
Part II
Date/Time Prepared:
4/2/2012 1:04 pm

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BUILDING & FIXT (SQUARE FEET)	NEW BUILDING & FIXT (SQUARE FEET)	14TH STREET (SQUARE FEET)	
		1.00	1.01	1.02	1.03	1.04	
1.00	Administrative and General	0	0	0	0	7,743	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	7,743	34.00
35.00	Total cost to be allocated	0	0	0	0	2,609	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000	0.336950	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2010
To 09/30/2011

Worksheet K-5
Part II
Date/Time Prepared:
4/2/2012 1:04 pm

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		MOB PHASE I (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.05	2.00	4.00	5A	5.00	
1.00	Administrative and General	0	23,515	377,878	0	118,624	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	338	0	75,335	4.00
5.00	Nursing Care	0	0	899,241	0	1,610,662	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	167,118	0	285,953	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	99,303	0	169,915	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	209,388	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	51,393	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	23,515	1,543,878		2,521,270	34.00
35.00	Total cost to be allocated	0	23,336	378,655		635,869	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.992388	0.245262		0.252202	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2010
To 09/30/2011

Worksheet K-5
Part II
Date/Time Prepared:
4/2/2012 1:04 pm

Hospice I

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		6.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	7,743	1,836	648	0	9,168	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)	7,743	1,836	648	0	9,168	34.00
35.00	Total cost to be allocated	131,783	1,668	22,426	0	78,316	35.00
36.00	Unit Cost Multiplier (see instructions)	17.019631	0.908497	34.608025	0.000000	8.542321	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2010
To 09/30/2011

Worksheet K-5
Part II
Date/Time Prepared:
4/2/2012 1:04 pm

Hospice I

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	
		13.00	16.00	20.00	21.00	22.00	
1.00	Administrative and General	65,746	0	40	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)	65,746	0	40	0	0	34.00
35.00	Total cost to be allocated	375,134	0	5,871	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	5.705807	0.000000	146.775000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2010
To 09/30/2011

Worksheet K-5
Part II
Date/Time Prepared:
4/2/2012 1:04 pm

Hospice I

	Cost Center Description	PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)		
		23.00	23.01	23.02		
1.00	Administrative and General	0	0	0		1.00
2.00	Inpatient - General Care	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0		3.00
4.00	Physician Services	0	0	0		4.00
5.00	Nursing Care	0	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0		6.00
7.00	Physical Therapy	0	0	0		7.00
8.00	Occupational Therapy	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0		9.00
10.00	Medical Social Services	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0		11.00
12.00	Dietary Counseling	0	0	0		12.00
13.00	Counseling - Other	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0		15.00
16.00	Other	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0		17.00
18.00	Analgesics	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0		19.00
20.00	Other - Specify	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0		21.00
22.00	Patient Transportation	0	0	0		22.00
23.00	Imaging Services	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0		24.00
25.00	Medical Supplies	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0		26.00
27.00	Radiation Therapy	0	0	0		27.00
28.00	Chemotherapy	0	0	0		28.00
29.00	Other	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0		31.00
32.00	Fundraising	0	0	0		32.00
33.00	Other Program Costs	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0		34.00
35.00	Total cost to be allocated	0	0	0		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 140015 Hospice CCN: 141501

Period: From 10/01/2010 To 09/30/2011

Worksheet K-5 Part III Date/Time Prepared: 4/2/2012 1:04 pm

Hospice I

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.542664	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.458023	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.278449	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.196217	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.129812	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.229773	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: 140015 Hospice CCN: 141501

Period: From 10/01/2010 To 09/30/2011

Worksheet K-6

Date/Time Prepared: 4/2/2012 1:04 pm

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				3,772,337	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				18,169	2.00
3.00	Average cost per diem (line 1 divided by line 2)				207.62	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	16,358				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	3,396,248				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		952			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		197,654			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		820			10.00
11.00	Aggregate NF cost (line 3 times line 10)		170,248			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			859		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			178,346		13.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140015	Period: From 10/01/2010 To 09/30/2011	Worksheet L Parts I-III Date/Time Prepared: 4/2/2012 1:04 pm
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier		3,213,367	1.00
2.00	Capital DRG outlier payments		207,120	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		120.54	3.00
4.00	Number of interns & residents (see instructions)		14.45	4.00
5.00	Indirect medical education percentage (see instructions)		3.44	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		110,540	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		3,531,027	12.00
			1.00	
	PART II - PAYMENT UNDER REASONABLE COST			
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
			1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 140015 Component CCN: 143422 | Period: From 10/01/2010 To 09/30/2011 | Worksheet M-1 | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	101,985	0	101,985	0	101,985	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	154,842	0	154,842	0	154,842	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	256,827	0	256,827	0	256,827	10.00
11.00	Physician Services Under Agreement	0	266,370	266,370	0	266,370	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	460	460	0	460	13.00
14.00	Subtotal (sum of lines 11-13)	0	266,830	266,830	0	266,830	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	30,353	30,353	-1,125	29,228	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	30,353	30,353	-1,125	29,228	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	256,827	297,183	554,010	-1,125	552,885	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	13,774	13,774	0	13,774	29.00
30.00	Administrative Costs	95,602	95,601	191,203	0	191,203	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	95,602	109,375	204,977	0	204,977	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	352,429	406,558	758,987	-1,125	757,862	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140015 Component CCN: 143422	Period: From 10/01/2010 To 09/30/2011	Worksheet M-1 Date/Time Prepared: 4/2/2012 1:04 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	101,985		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	154,842		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	256,827		10.00
11.00	Physician Services Under Agreement	0	266,370		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	460		13.00
14.00	Subtotal (sum of lines 11-13)	0	266,830		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	29,228		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	29,228		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	552,885		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	13,774		29.00
30.00	Administrative Costs	-17,990	173,213		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-17,990	186,987		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-17,990	739,872		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES | Provider CCN: 140015 | Component CCN: 143422 | Period: From 10/01/2010 To 09/30/2011 | Worksheet M-2 | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.00	4,565	4,200	4,200		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.88	3,039	2,100	1,848		3.00
4.00	Subtotal (sum of lines 1-3)	1.88	7,604		6,048	7,604	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.88	7,604			7,604	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					552,885	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					552,885	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					186,987	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					295,458	15.00
16.00	Total overhead (sum of lines 14 and 15)					482,445	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					482,445	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					482,445	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,035,330	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 140015 Component CCN: 143422 | Period: From 10/01/2010 To 09/30/2011 | Worksheet M-3 Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Rural Health Clinic (RHC) I | Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,035,330	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		16,688	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,018,642	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		7,604	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		7,604	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		133.96	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	77.76	78.07	8.00
9.00	Rate for Program covered visits (see instructions)	77.76	78.07	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	546	1,832	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	42,457	143,024	11.00
12.00	Program covered visits for mental health services (from contractor records)	10	27	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	778	2,108	13.00
14.00	Limit adjustment for mental health services (see instructions)	535	1,449	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	42,992	144,473	16.00
16.01	Total program charges (see instructions)(from contractor's records)		309,993	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		85,984	16.04
16.05	Total program cost (see instructions)	34,394	85,984	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		36,993	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		55,806	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		120,378	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,607	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		126,985	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		126,985	26.00
27.00	Interim payments		118,052	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		8,933	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		181	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 140015 | Component CCN: 143422 | Period: From 10/01/2010 To 09/30/2011 | Worksheet M-4 | Date/Time Prepared: 4/2/2012 1:04 pm

Title XVIII | Rural Health Clinic (RHC) I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	256,827	256,827	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000254	0.005454	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	65	1,401	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,300	6,146	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,365	7,547	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	552,885	552,885	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	482,445	482,445	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002469	0.013650	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,191	6,585	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,556	14,132	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	24	516	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	106.50	27.39	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	7	214	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	746	5,861	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		16,688	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		6,607	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140015 Component CCN: 143422	Period: From 10/01/2010 To 09/30/2011	Worksheet M-5 Date/Time Prepared: 4/2/2012 1:04 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		118,052	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	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	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		118,052	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	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		8,933	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		126,985	7.00

			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00