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: 140120

Period:
From 05/01/2012
To 04/30/2013

Worksheet S
Parts I-III
Date/Time Prepared:
9/25/2013 9:10 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/25/2013 Time: 9:10 am
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. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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 certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PEKIN MEMORIAL HOSPITAL (140120) for the cost reporting period beginning 05/01/2012 and ending 04/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	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	62,253	58,573	75,423	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
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	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	117		0	9.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	62,253	58,690	75,423	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 9/25/2013 9:09 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 600 SOUTH 13TH STREET	PO Box:			1.00
2.00	City: PEKIN	State: IL	Zip Code: 61554	County: TAZWELL	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	PEKIN MEMORIAL HOSPITAL	140120	37900	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	PEKIN MEMORIAL HOSPITAL SNF	145766	37900		10/01/1993	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	PEKIN HOME HEALTH	147057	37900		01/01/1966	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	05/01/2012	04/30/2013	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,287	420	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

		Urban/Rural S 1.00	Date of Geogr 2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part I Date/Time Prepared: 9/25/2013 9:09 am

		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.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.	N	N	39.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	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)	N			60.00

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	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, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part I Date/Time Prepared: 9/25/2013 9:09 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 9/25/2013 9:09 am

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	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.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N		0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 9/25/2013 9:09 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	734,213	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H076	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: PROGRESSIVE HEALTH SYSTEMS	Contractor's Name: NATIONAL GOVERNMENT SERVICES, INC	Contractor's Number: 00131	141.00
142.00	Street: 600 SOUTH 13TH STREET	PO Box:		142.00
143.00	City: PEKIN	State: IL	Zip Code: 61554	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

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

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140120	Period: From 05/01/2012 To 04/30/2013	Worksheet S-2 Part I Date/Time Prepared: 9/25/2013 9:09 am

							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
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						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: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 9/25/2013 9:09 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

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

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	08/23/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part II Date/Time Prepared: 9/25/2013 9:09 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been 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	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.				N	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.	N		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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544	KWELLEN@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 9/25/2013 9:09 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	08/23/2013			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-3 Part I Date/Time Prepared: 9/25/2013 9:09 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	90	32,850	0.00	0	1.00
2.00	HMO						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		90	32,850	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		98	35,770	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	1	405		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	99.00				0	25.00
25.10	CMHC - CORF	99.10				0	25.10
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		99				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 9/25/2013 9:09 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	7,915	1,459	13,238			1.00
2.00	HMO	1,624	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	7,915	1,459	13,238			7.00
8.00	INTENSIVE CARE UNIT	697	107	1,286			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		578	885			13.00
14.00	Total (see instructions)	8,612	2,144	15,409	0.00	535.80	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	89	0	89	0.00	1.02	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	6,515	0	9,596	0.00	9.05	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	0	0	0	0.00	0.00	25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	545.87	27.00
28.00	Observation Bed Days		448	2,571			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			134			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		62	84			32.00
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 9/25/2013 9:09 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	1,683	628	3,447	1.00
2.00	HMO			303			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,683	628	3,447	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	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					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	0.00					25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-3 Part II Date/Time Prepared: 9/25/2013 9:09 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	27,665,159	0	27,665,159	1,135,409.62	24.37	1.00
2.00	Non-physician anesthetist Part A		1,914,898	0	1,914,898	20,591.00	93.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		1,946,626	0	1,946,626	49,628.37	39.22	8.00
9.00	SNF	44.00	21,662	0	21,662	2,123.66	10.20	9.00
10.00	Excluded area salaries (see instructions)		543,130	0	543,130	20,533.92	26.45	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		1,510,802	0	1,510,802	26,357.45	57.32	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		1,623,831	0	1,623,831	41,626.11	39.01	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		6,839,587	0	6,839,587			17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25		0	0	0			18.00
19.00	Excluded areas		141,751	0	141,751			19.00
20.00	Non-physician anesthetist Part A		264,801	0	264,801			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits	4.00	587	203,058	203,645	8,212.75	24.80	26.00
27.00	Administrative & General	5.00	5,102,441	-203,058	4,899,383	215,078.90	22.78	27.00
28.00	Administrative & General under contract (see inst.)		729,288	0	729,288	1,834.15	397.62	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	507,561	0	507,561	22,016.90	23.05	30.00
31.00	Laundry & Linen Service	8.00	138,335	0	138,335	11,882.81	11.64	31.00
32.00	Housekeeping	9.00	733,994	0	733,994	65,441.70	11.22	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	659,356	-492,212	167,144	13,061.58	12.80	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	492,212	492,212	38,463.39	12.80	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	868,681	0	868,681	26,783.52	32.43	38.00
39.00	Central Services and Supply	14.00	70,293	0	70,293	5,207.53	13.50	39.00
40.00	Pharmacy	15.00	796,659	0	796,659	22,781.88	34.97	40.00
41.00	Medical Records & Medical Records Library	16.00	640,488	0	640,488	37,435.57	17.11	41.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-3 Part II Date/Time Prepared: 9/25/2013 9:09 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-3 Part III Date/Time Prepared: 9/25/2013 9:09 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		24,532,923	0	24,532,923	1,067,024.40	22.99	1.00
2.00	Excluded area salaries (see instructions)		564,792	0	564,792	22,657.58	24.93	2.00
3.00	Subtotal salaries (line 1 minus line 2)		23,968,131	0	23,968,131	1,044,366.82	22.95	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,134,633	0	3,134,633	67,983.56	46.11	4.00
5.00	Subtotal wage-related costs (see inst.)		6,839,587	0	6,839,587	0.00	28.54	5.00
6.00	Total (sum of lines 3 thru 5)		33,942,351	0	33,942,351	1,112,350.38	30.51	6.00
7.00	Total overhead cost (see instructions)		10,247,683	0	10,247,683	468,200.68	21.89	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-3 Part IV Date/Time Prepared: 9/25/2013 9:09 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,092,476	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	491,348	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	139,188	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	32,734	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)	2,581,302	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)	23,306	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	498,807	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,950,235	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	19,237	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	10,954	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,839,587	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: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-3 Part V Date/Time Prepared: 9/25/2013 9:09 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	2,339,805	179,435	1.00
2.00	Hospital	2,060,655	179,435	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	482	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	278,668	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC	0	0	16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 140120 | Component CCN: 147057 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-4 | Date/Time Prepared: 9/25/2013 9:09 am

Home Health Agency I | PPS

		1.00	
0.00	County	TAZWELL	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	888	0	5	893	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	411.00	16.00	112.00	539.00	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)		1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel		2.00	0.00	2.00	5.00
6.00	Direct Nursing Service		4.62	0.00	4.62	6.00
7.00	Nursing Supervisor		1.00	0.00	1.00	7.00
8.00	Physical Therapy Service		0.00	1.73	1.73	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.18	0.18	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.07	0.07	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.43	0.00	0.43	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).		37900			20.00
20.01			99914			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	2,738	61	75	67	2,941	21.00
22.00	Skilled Nursing Visit Charges	476,586	10,614	13,050	11,658	511,908	22.00
23.00	Physical Therapy Visits	2,259	22	20	16	2,317	23.00
24.00	Physical Therapy Visit Charges	429,210	4,180	3,800	3,040	440,230	24.00
25.00	Occupational Therapy Visits	283	12	0	0	295	25.00
26.00	Occupational Therapy Visit Charges	54,336	2,304	0	0	56,640	26.00
27.00	Speech Pathology Visits	103	12	1	0	116	27.00
28.00	Speech Pathology Visit Charges	21,321	2,484	207	0	24,012	28.00
29.00	Medical Social Service Visits	0	0	0	1	1	29.00
30.00	Medical Social Service Visit Charges	0	0	0	279	279	30.00
31.00	Home Health Aide Visits	775	28	1	41	845	31.00
32.00	Home Health Aide Visit Charges	61,225	2,212	79	3,239	66,755	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	6,158	135	97	125	6,515	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)	1,042,678	21,794	17,136	18,216	1,099,824	35.00
36.00	Total Number of Episodes (standard/non outlier)	347		37	11	395	36.00
37.00	Total Number of Outlier Episodes		3		0	3	37.00
38.00	Total Non-Routine Medical Supply Charges	10,124	149	372	161	10,806	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-7 | Date/Time Prepared: 9/25/2013 9:09 am

		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.	N		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	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	10	0	10	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	27	0	27	17.00
18.00		RHC	27	0	27	18.00
19.00		RHB	8	0	8	19.00
20.00		RHA	6	0	6	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	11	0	11	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-7 | Date/Time Prepared: 9/25/2013 9:09 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		89	0	89	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).	37900	37900	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	21,662	55.05	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)	6,224	15.82	Y	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	39,353			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-10 | Date/Time Prepared: 9/25/2013 9:09 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.225671	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,424,600	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	2,158,104	5.00
6.00	Medicaid charges	34,260,860	6.00
7.00	Medicaid cost (line 1 times line 6)	7,731,683	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,148,979	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	21,652	9.00
10.00	Stand-alone SCHIP charges	255,115	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	57,572	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	35,920	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)	2,184,899	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	5,747,742	0	5,747,742	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,297,099	0	1,297,099	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,297,099	0	1,297,099	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)	8,673,275	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	321,609	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	8,351,666	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	1,884,729	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	3,181,828	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,366,727	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A | Date/Time Prepared: 9/25/2013 9:09 am

		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	00100	CAP REL COSTS-BLDG & FIXT		1,338,655	1,338,655	927,043	2,265,698	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,464,641	2,464,641	48,776	2,513,417	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	587	6,473,186	6,473,773	527,383	7,001,156	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,102,441	8,187,435	13,289,876	-1,287,086	12,002,790	5.00
7.00	00700	OPERATION OF PLANT	507,561	1,373,247	1,880,808	15,698	1,896,506	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	138,335	111,234	249,569	0	249,569	8.00
9.00	00900	HOUSEKEEPING	733,994	360,163	1,094,157	0	1,094,157	9.00
10.00	01000	DIETARY	659,356	848,271	1,507,627	-1,155,450	352,177	10.00
11.00	01100	CAFETERIA	0	0	0	1,155,450	1,155,450	11.00
13.00	01300	NURSING ADMINISTRATION	868,681	54,436	923,117	-85	923,032	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	70,293	289,337	359,630	-271,027	88,603	14.00
15.00	01500	PHARMACY	796,659	2,292,402	3,089,061	-1,980,945	1,108,116	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	640,488	157,186	797,674	-2,264	795,410	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,019,560	553,077	6,572,637	-1,083,593	5,489,044	30.00
31.00	03100	INTENSIVE CARE UNIT	1,228,802	80,441	1,309,243	-3,356	1,305,887	31.00
43.00	04300	NURSERY	0	0	0	223,918	223,918	43.00
44.00	04400	SKILLED NURSING FACILITY	21,662	6,224	27,886	1,783	29,669	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,112,049	4,055,005	6,167,054	-3,550,648	2,616,406	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	639,391	639,391	52.00
53.00	05300	ANESTHESIOLOGY	1,948,970	174,340	2,123,310	-82,322	2,040,988	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,192,100	439,366	1,631,466	125,944	1,757,410	54.00
56.00	05600	RADIOISOTOPE	135,416	362,964	498,380	288	498,668	56.00
57.00	05700	CT SCAN	239,272	279,185	518,457	59,836	578,293	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	149,173	56,299	205,472	-36,498	168,974	58.00
59.00	05900	CARDIAC CATHETERIZATION	273,774	378,127	651,901	-351,925	299,976	59.00
60.00	06000	LABORATORY	1,067,667	1,286,362	2,354,029	-76,250	2,277,779	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	598,040	598,040	37,133	635,173	63.00
65.00	06500	RESPIRATORY THERAPY	365,668	77,646	443,314	-38,605	404,709	65.00
66.00	06600	PHYSICAL THERAPY	0	535,700	535,700	47	535,747	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	95,925	95,925	0	95,925	67.00
68.00	06800	SPEECH PATHOLOGY	0	152,885	152,885	3,493	156,378	68.00
69.00	06900	ELECTROCARDIOLOGY	437,747	329,755	767,502	9,512	777,014	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,460,295	3,460,295	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,768,421	1,768,421	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,029,549	2,029,549	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	0	130,690	130,690	-60	130,630	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	114,835	15,842	130,677	-4,552	126,125	90.00
91.00	09100	EMERGENCY	2,296,939	354,859	2,651,798	-253,477	2,398,321	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	525,468	374,944	900,412	-14,479	885,933	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		841,338	841,338	-841,338	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,647,497	35,129,207	62,776,704	0	62,776,704	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,662	1,392	19,054	0	19,054	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	RENTED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	27,665,159	35,130,599	62,795,758	0	62,795,758	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A | Date/Time Prepared: 9/25/2013 9:09 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	17,488	2,283,186		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-166,313	2,347,104		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS	-1,186,357	5,814,799		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,936,380	9,066,410		5.00
7.00	00700	OPERATION OF PLANT	0	1,896,506		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-1,670	247,899		8.00
9.00	00900	HOUSEKEEPING	0	1,094,157		9.00
10.00	01000	DIETARY	0	352,177		10.00
11.00	01100	CAFETERIA	-534,792	620,658		11.00
13.00	01300	NURSING ADMINISTRATION	-9,530	913,502		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-4,635	83,968		14.00
15.00	01500	PHARMACY	-308	1,107,808		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-24,947	770,463		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-380	5,488,664		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,305,887		31.00
43.00	04300	NURSERY	-796	223,122		43.00
44.00	04400	SKILLED NURSING FACILITY	-4,978	24,691		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,616,406		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	639,391		52.00
53.00	05300	ANESTHESIOLOGY	-1,914,898	126,090		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-7,733	1,749,677		54.00
56.00	05600	RADIOISOTOPE	0	498,668		56.00
57.00	05700	CT SCAN	0	578,293		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	168,974		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	299,976		59.00
60.00	06000	LABORATORY	-69,468	2,208,311		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	635,173		63.00
65.00	06500	RESPIRATORY THERAPY	0	404,709		65.00
66.00	06600	PHYSICAL THERAPY	-4,570	531,177		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	95,925		67.00
68.00	06800	SPEECH PATHOLOGY	0	156,378		68.00
69.00	06900	ELECTROCARDIOLOGY	-306,037	470,977		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,460,295		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,768,421		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,029,549		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	SLEEP LAB	-130,526	104		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	126,125		90.00
91.00	09100	EMERGENCY	0	2,398,321		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.00	09900	CMHC	0	0		99.00
99.10	09910	CORF	0	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	885,933		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,286,830	55,489,874		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,054		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07951	RENTED SPACE	0	0		194.01
194.02	07952	FOUNDATION	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-7,286,830	55,508,928		200.00

RECLASSIFICATIONS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-6 | Date/Time Prepared: 9/25/2013 9:09 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	492,212	663,238		1.00
	TOTALS		492,212	663,238		
	B - TO RECLASS BLOOD SALARIES FROM LAB					
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	48,581	0		1.00
	TOTALS		48,581	0		
	C - TO RECLASS LDR EXPENSES					
1.00	NURSERY	43.00	213,479	6,296		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	609,581	17,978		2.00
	TOTALS		823,060	24,274		
	D - TO RECLASS CLINICAL ENGINEERING EXPE					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	32,068		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	14,585		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	3,912		3.00
4.00	NURSERY	43.00	0	4,143		4.00
5.00	SKILLED NURSING FACILITY	44.00	0	2,045		5.00
6.00	OPERATING ROOM	50.00	0	110,676		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	11,832		7.00
8.00	ANESTHESIOLOGY	53.00	0	38,571		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	177,478		9.00
10.00	RADIOISOTOPE	56.00	0	5,400		10.00
11.00	CT SCAN	57.00	0	111,791		11.00
12.00	CARDIAC CATHETERIZATION	59.00	0	11,886		12.00
13.00	LABORATORY	60.00	0	34,578		13.00
14.00	RESPIRATORY THERAPY	65.00	0	25,165		14.00
15.00	PHYSICAL THERAPY	66.00	0	3,002		15.00
16.00	SPEECH PATHOLOGY	68.00	0	3,518		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	14,825		17.00
18.00	CLINIC	90.00	0	8,420		18.00
19.00	EMERGENCY	91.00	0	11,809		19.00
	TOTALS		0	625,704		
	E - TO RECLASS SUPPLY COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,460,295		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,768,421		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	5,228,716		
	F - TO RECLASS BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,029,549		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
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00

RECLASSIFICATIONS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-6 | Date/Time Prepared: 9/25/2013 9:09 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	TOTALS		0	2,029,549		
	G - TO RECLASS TELEPHONE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,417		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	5,417		
	H - TO RECLASS HUMAN RESOURCES					
1.00	EMPLOYEE BENEFITS	4.00	203,058	324,325		1.00
	TOTALS		203,058	324,325		
	I - TO RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	841,338		1.00
	TOTALS		0	841,338		
	J - TO RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	134,481		1.00
	TOTALS		0	134,481		
	K - TO RECLASS MRI LEASE EXPENSE					
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	4,935		1.00
	TOTALS		0	4,935		
	L - TO RECLASS MRI BUILDING UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	15,698		1.00
	TOTALS		0	15,698		
500.00	Grand Total: Increases		1,566,911	9,897,675		500.00

RECLASSIFICATIONS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-6 | Date/Time Prepared: 9/25/2013 9:09 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - TO RECLASS CAFETERIA COSTS					
1.00	DIETARY	10.00	492,212	663,238	0	1.00
	TOTALS		492,212	663,238		
	B - TO RECLASS BLOOD SALARIES FROM LAB					
1.00	LABORATORY	60.00	48,581	0	0	1.00
	TOTALS		48,581	0		
	C - TO RECLASS LDR EXPENSES					
1.00	ADULTS & PEDIATRICS	30.00	823,060	24,274	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		823,060	24,274		
	D - TO RECLASS CLINICAL ENGINEERING EXPE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	625,704	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
	TOTALS		0	625,704		
	E - TO RECLASS SUPPLY COSTS					
1.00	NURSING ADMINISTRATION	13.00	0	85	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	286,259	0	2.00
3.00	PHARMACY	15.00	0	16,751	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	250,688	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	7,252	0	5.00
6.00	SKILLED NURSING FACILITY	44.00	0	262	0	6.00
7.00	OPERATING ROOM	50.00	0	3,656,909	0	7.00
8.00	ANESTHESIOLOGY	53.00	0	117,715	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	46,046	0	9.00
10.00	RADIOISOTOPE	56.00	0	5,112	0	10.00
11.00	CT SCAN	57.00	0	38,426	0	11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	23,851	0	12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	359,456	0	13.00
14.00	LABORATORY	60.00	0	62,247	0	14.00
15.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	487	0	15.00
16.00	RESPIRATORY THERAPY	65.00	0	63,769	0	16.00
17.00	PHYSICAL THERAPY	66.00	0	2,955	0	17.00
18.00	SPEECH PATHOLOGY	68.00	0	25	0	18.00
19.00	ELECTROCARDIOLOGY	69.00	0	5,309	0	19.00
20.00	SLEEP LAB	76.00	0	60	0	20.00
21.00	CLINIC	90.00	0	12,962	0	21.00
22.00	EMERGENCY	91.00	0	257,611	0	22.00
23.00	HOME HEALTH AGENCY	101.00	0	14,479	0	23.00
	TOTALS		0	5,228,716		
	F - TO RECLASS BILLABLE DRUGS					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	16,836	0	1.00
2.00	PHARMACY	15.00	0	1,964,194	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	156	0	3.00
4.00	INTENSIVE CARE UNIT	31.00	0	16	0	4.00
5.00	OPERATING ROOM	50.00	0	4,415	0	5.00
6.00	ANESTHESIOLOGY	53.00	0	3,178	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,219	0	7.00
8.00	CT SCAN	57.00	0	13,529	0	8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	4,355	0	9.00
10.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	10,961	0	10.00
11.00	RESPIRATORY THERAPY	65.00	0	1	0	11.00
12.00	ELECTROCARDIOLOGY	69.00	0	4	0	12.00
13.00	CLINIC	90.00	0	10	0	13.00
14.00	EMERGENCY	91.00	0	7,675	0	14.00

RECLASSIFICATIONS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-6 | Date/Time Prepared: 9/25/2013 9:09 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	TOTALS		0	2,029,549			
	G - TO RECLASS TELEPHONE EXPENSE						
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,264	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,269	0		2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,884	0		3.00
	TOTALS		0	5,417			
	H - TO RECLASS HUMAN RESOURCES						
1.00	ADMINISTRATIVE & GENERAL	5.00	203,058	324,325	0		1.00
	TOTALS		203,058	324,325			
	I - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	841,338	11		1.00
	TOTALS		0	841,338			
	J - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	134,481	0		1.00
	TOTALS		0	134,481			
	K - TO RECLASS MRI LEASE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,935	0		1.00
	TOTALS		0	4,935			
	L - TO RECLASS MRI BUILDING UTILITIES						
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	15,698	0		1.00
	TOTALS		0	15,698			
500.00	Grand Total: Decreases		1,566,911	9,897,675			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-7 Part I | Date/Time Prepared: 9/25/2013 9:09 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: 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	1,449,581	0	0	0	0	1.00
2.00	Land Improvements	1,801,151	26,065	0	26,065	0	2.00
3.00	Buildings and Fixtures	11,554,361	31,585	0	31,585	0	3.00
4.00	Building Improvements	17,546,628	751,055	0	751,055	0	4.00
5.00	Fixed Equipment	14,765,261	1,926,794	0	1,926,794	97,553	5.00
6.00	Movable Equipment	26,809,285	2,049,510	0	2,049,510	141,775	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	73,926,267	4,785,009	0	4,785,009	239,328	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	73,926,267	4,785,009	0	4,785,009	239,328	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,449,581	0	1.00
2.00	Land Improvements	1,827,216	0	2.00
3.00	Buildings and Fixtures	11,585,946	0	3.00
4.00	Building Improvements	18,297,683	0	4.00
5.00	Fixed Equipment	16,594,502	0	5.00
6.00	Movable Equipment	28,717,020	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	78,471,948	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	78,471,948	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-7 Part II | Date/Time Prepared: 9/25/2013 9:09 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,298,203	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,464,641	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,762,844	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	40,452	1,338,655	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,464,641	2.00
3.00	Total (sum of lines 1-2)	40,452	3,803,296	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-7 Part III Date/Time Prepared: 9/25/2013 9:09 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	49,754,928	0	49,754,928	0.637299	85,705	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	28,717,020	400,341	28,316,679	0.362701	48,776	2.00
3.00	Total (sum of lines 1-2)	78,471,948	400,341	78,071,607	1.000000	134,481	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	85,705	1,324,924	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	48,776	2,298,328	0	2.00
3.00	Total (sum of lines 1-2)	0	0	134,481	3,623,252	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	832,105	85,705	0	40,452	2,283,186	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	48,776	0	0	2,347,104	2.00
3.00	Total (sum of lines 1-2)	832,105	134,481	0	40,452	4,630,290	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-8 | Date/Time Prepared: 9/25/2013 9:09 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-9,233	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-483,475			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-2,625,655			0	12.00
13.00	Laundry and linen service	B	-1,670	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-365,667	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-4,635	CENTRAL SERVICES & SUPPLY	14.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-24,947	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	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	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	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	0	32.00
33.00	MOW & CATERING	B	-169,125	CAFETERIA	11.00	0	33.00
33.01	WELLNESS CENTER AND AEROBICS CLASSES	B	-20,588	ELECTROCARDIOLOGY	69.00	0	33.01
33.02	PHYSICAL THERAPY OTHER INCOME	B	-4,570	PHYSICAL THERAPY	66.00	0	33.02

ADJUSTMENTS TO EXPENSES | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-8 | Date/Time Prepared: 9/25/2013 9:09 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.03	EDUCATION REVENUE	B	-9,530	NURSING ADMINISTRATION	13.00	0	33.03
33.04	SICKBAY REVENUE	B	-380	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	RADIOLOGY TRANSCRIPT REVENUE	B	-7,733	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	NURSERY OTHER INCOME	B	-796	NURSERY	43.00	0	33.06
33.07	CORONER AUTOPSY FEES	B	-1,968	LABORATORY	60.00	0	33.07
33.08	CASH ADJUSTMENTS	B	934	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	MISCELLANEOUS OTHER INCOME	B	-13,846	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	DEPRECIATION LAPSING SCHEDULES	A	26,721	CAP REL COSTS-BLDG & FIXT	1.00	9	33.10
33.11	ADVERTISING SALARY EXPENSE	A	-154,614	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	ADVERTISING EXPENSE	A	-448,467	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	ADVERTISING BENEFITS	A	-31,343	EMPLOYEE BENEFITS	4.00	0	33.13
33.14	CRNA SALARIES	A	-1,914,898	ANESTHESIOLOGY	53.00	0	33.14
33.15	CRNA EMPLOYEE BENEFITS	A	-156,551	EMPLOYEE BENEFITS	4.00	0	33.15
33.16	BOOK FAIR PROCEEDS	B	-1,782	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	FEDERAL EXCISE TAX	A	-308	PHARMACY	15.00	0	33.17
33.18	IDPA BED TAX	A	-4,978	SKILLED NURSING FACILITY	44.00	0	33.18
33.19	SELF INSURANCE EXPENSE	A	-913,188	EMPLOYEE BENEFITS	4.00	0	33.19
33.20	HEALTHLINK FEES	A	55,462	ADMINISTRATIVE & GENERAL	5.00	0	33.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,286,830				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-8-1 | Date/Time Prepared: 9/25/2013 9:09 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAP REL COSTS- MVBLE	923,939	1,090,252	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE/FINANCE/IS	3,575,853	4,403,587	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	PROVIDER TAX HOSPITAL	0	1,546,333	3.00
4.00	4.00	EMPLOYEE BENEFITS	HUMAN RESOURCES	442,108	527,383	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,941,900	7,567,555	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		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B		0.00	PROGRESSIVE HC	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 140120	Period: From 05/01/2012 To 04/30/2013	Worksheet A-8-1 Date/Time Prepared: 9/25/2013 9:09 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	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	-166,313	9		1.00
2.00	-827,734	0		2.00
3.00	-1,546,333	0		3.00
4.00	-85,275	0		4.00
5.00	-2,625,655			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		
	Type of Business		
	6.00		
	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	MANAGEMENT CO		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-8-2 | Date/Time Prepared: 9/25/2013 9:09 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	76.00	SLEEP LAB	130,526	130,526	0	0	0	1.00
2.00	60.00	LABORATORY	67,500	67,500	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	285,449	285,449	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			483,475	483,475	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	76.00	SLEEP LAB	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	76.00	SLEEP LAB	0	0	0	130,526		1.00
2.00	60.00	LABORATORY	0	0	0	67,500		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	285,449		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	483,475		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part I Date/Time Prepared: 9/25/2013 9:09 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,283,186	2,283,186				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,347,104		2,347,104			2.00
4.00	00400	EMPLOYEE BENEFITS	5,814,799	9,895	1,264	5,825,958		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,066,410	637,866	921,165	1,088,645	11,714,086	5.00
7.00	00700	OPERATION OF PLANT	1,896,506	420,610	37,267	116,455	2,470,838	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	247,899	25,085	16,538	31,740	321,262	8.00
9.00	00900	HOUSEKEEPING	1,094,157	1,992	515	168,408	1,265,072	9.00
10.00	01000	DIETARY	352,177	47,757	20,396	38,350	458,680	10.00
11.00	01100	CAFETERIA	620,658	13,358	0	112,934	746,950	11.00
13.00	01300	NURSING ADMINISTRATION	913,502	30,280	55,474	199,311	1,198,567	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	83,968	34,767	66,809	16,128	201,672	14.00
15.00	01500	PHARMACY	1,107,808	11,500	13,830	182,786	1,315,924	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	770,463	28,736	18,298	146,954	964,451	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,488,664	235,196	60,969	1,192,281	6,977,110	30.00
31.00	03100	INTENSIVE CARE UNIT	1,305,887	26,650	9,278	281,938	1,623,753	31.00
43.00	04300	NURSERY	223,122	6,927	7,981	48,981	287,011	43.00
44.00	04400	SKILLED NURSING FACILITY	24,691	3,751	8,688	4,970	42,100	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,616,406	136,947	309,560	484,591	3,547,504	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	639,391	22,465	22,788	139,863	824,507	52.00
53.00	05300	ANESTHESIOLOGY	126,090	2,333	75,120	7,818	211,361	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,749,677	104,648	425,761	273,517	2,553,603	54.00
56.00	05600	RADIOISOTOPE	498,668	5,850	2,882	31,070	538,470	56.00
57.00	05700	CT SCAN	578,293	5,148	4,041	54,899	642,381	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	168,974	13,586	51,573	34,226	268,359	58.00
59.00	05900	CARDIAC CATHETERIZATION	299,976	5,115	27,881	62,815	395,787	59.00
60.00	06000	LABORATORY	2,208,311	40,242	64,111	233,820	2,546,484	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	635,173	0	1,310	11,146	647,629	63.00
65.00	06500	RESPIRATORY THERAPY	404,709	10,203	25,746	83,899	524,557	65.00
66.00	06600	PHYSICAL THERAPY	531,177	23,086	2,828	0	557,091	66.00
67.00	06700	OCCUPATIONAL THERAPY	95,925	3,323	58	0	99,306	67.00
68.00	06800	SPEECH PATHOLOGY	156,378	12,356	0	0	168,734	68.00
69.00	06900	ELECTROCARDIOLOGY	470,977	40,557	72,562	100,437	684,533	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,460,295	0	0	0	3,460,295	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,768,421	0	0	0	1,768,421	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,029,549	0	0	0	2,029,549	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	104	4,948	0	0	5,052	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	126,125	13,512	2,185	26,348	168,170	90.00
91.00	09100	EMERGENCY	2,398,321	98,370	17,978	527,012	3,041,681	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	885,933	13,372	693	120,564	1,020,562	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,489,874	2,090,431	2,345,549	5,821,906	55,291,512	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,054	33,256	1,446	4,052	57,808	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	122,265	109	0	122,374	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	RENTED SPACE	0	33,918	0	0	33,918	194.01
194.02	07952	FOUNDATION	0	3,316	0	0	3,316	194.02
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)	55,508,928	2,283,186	2,347,104	5,825,958	55,508,928	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part I | Date/Time Prepared: 9/25/2013 9:09 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,714,086					5.00
7.00	00700	OPERATION OF PLANT	660,890	3,131,728				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	85,930	64,669	471,861			8.00
9.00	00900	HOUSEKEEPING	338,376	5,136	5,936	1,614,520		9.00
10.00	01000	DIETARY	122,686	123,116	376	64,918	769,776	10.00
11.00	01100	CAFETERIA	199,791	34,437	0	18,158	0	11.00
13.00	01300	NURSING ADMINISTRATION	320,588	78,061	0	41,161	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	53,942	89,627	1,489	47,259	0	14.00
15.00	01500	PHARMACY	351,978	29,646	0	15,632	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	257,967	74,080	0	39,062	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,866,227	606,325	149,062	319,708	710,508	30.00
31.00	03100	INTENSIVE CARE UNIT	434,315	68,702	70,027	36,226	57,492	31.00
43.00	04300	NURSERY	76,769	17,856	7,952	9,415	0	43.00
44.00	04400	SKILLED NURSING FACILITY	11,261	9,669	21,468	5,099	1,776	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	948,872	353,043	64,934	186,156	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	220,536	57,913	22,707	30,537	0	52.00
53.00	05300	ANESTHESIOLOGY	56,534	6,015	0	3,172	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	683,028	269,776	36,054	142,250	0	54.00
56.00	05600	RADIOISOTOPE	144,028	15,081	0	7,952	0	56.00
57.00	05700	CT SCAN	171,822	13,272	0	6,998	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	71,780	35,023	3,014	18,467	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	105,864	13,185	0	6,953	0	59.00
60.00	06000	LABORATORY	681,123	103,743	141	54,703	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	173,225	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	140,306	26,302	0	13,869	0	65.00
66.00	06600	PHYSICAL THERAPY	149,008	59,516	7,121	31,382	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,562	8,566	0	4,517	0	67.00
68.00	06800	SPEECH PATHOLOGY	45,132	31,852	0	16,795	0	68.00
69.00	06900	ELECTROCARDIOLOGY	183,096	104,553	899	55,130	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	925,546	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	473,010	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	542,856	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	1,351	12,755	878	6,725	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	44,981	34,834	0	18,367	0	90.00
91.00	09100	EMERGENCY	813,577	253,592	64,046	133,716	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	272,976	34,472	0	18,177	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,655,933	2,634,817	456,104	1,352,504	769,776	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,462	85,731	0	45,205	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	32,732	315,193	15,329	166,198	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	RENTED SPACE	9,072	87,438	428	46,105	0	194.01
194.02	07952	FOUNDATION	887	8,549	0	4,508	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	11,714,086	3,131,728	471,861	1,614,520	769,776	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part I Date/Time Prepared: 9/25/2013 9:09 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	999,336					11.00
13.00	01300	NURSING ADMINISTRATION	35,170	1,673,547				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,826	0	400,815			14.00
15.00	01500	PHARMACY	29,900	0	686	1,743,766		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	49,150	0	784	0	1,385,494	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	286,379	1,465,195	5,242	431	812,388	30.00
31.00	03100	INTENSIVE CARE UNIT	53,929	118,558	488	637	39,481	31.00
43.00	04300	NURSERY	10,322	81,589	142	86	59,480	43.00
44.00	04400	SKILLED NURSING FACILITY	2,785	8,205	8	0	18,446	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	106,602	0	5,195	1,727	292,176	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,436	0	406	247	0	52.00
53.00	05300	ANESTHESIOLOGY	29,791	0	651	15,583	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	70,886	0	1,534	2,240	0	54.00
56.00	05600	RADIOISOTOPE	5,161	0	14	1,693	0	56.00
57.00	05700	CT SCAN	11,059	0	21	90	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,448	0	120	1,075	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	11,141	0	108	0	0	59.00
60.00	06000	LABORATORY	61,083	0	2,044	653	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,922	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	22,555	0	389	309	111,760	65.00
66.00	06600	PHYSICAL THERAPY	0	0	241	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	23,183	0	353	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	249,426	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	127,473	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,718,576	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	0	0	7	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13,298	0	202	0	0	90.00
91.00	09100	EMERGENCY	101,359	0	4,739	0	51,763	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	24,712	0	453	419	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	997,097	1,673,547	400,726	1,743,766	1,385,494	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,239	0	89	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	RENTED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	999,336	1,673,547	400,815	1,743,766	1,385,494	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part I | Date/Time Prepared: 9/25/2013 9:09 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	13,198,575	0	13,198,575		30.00
31.00	03100	INTENSIVE CARE UNIT	2,503,608	0	2,503,608		31.00
43.00	04300	NURSERY	550,622	0	550,622		43.00
44.00	04400	SKILLED NURSING FACILITY	120,817	0	120,817		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,506,209	0	5,506,209		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,186,289	0	1,186,289		52.00
53.00	05300	ANESTHESIOLOGY	323,107	0	323,107		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,759,371	0	3,759,371		54.00
56.00	05600	RADIOISOTOPE	712,399	0	712,399		56.00
57.00	05700	CT SCAN	845,643	0	845,643		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	407,286	0	407,286		58.00
59.00	05900	CARDIAC CATHETERIZATION	533,038	0	533,038		59.00
60.00	06000	LABORATORY	3,449,974	0	3,449,974		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	823,776	0	823,776		63.00
65.00	06500	RESPIRATORY THERAPY	840,047	0	840,047		65.00
66.00	06600	PHYSICAL THERAPY	804,359	0	804,359		66.00
67.00	06700	OCCUPATIONAL THERAPY	138,951	0	138,951		67.00
68.00	06800	SPEECH PATHOLOGY	262,513	0	262,513		68.00
69.00	06900	ELECTROCARDIOLOGY	1,051,747	0	1,051,747		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,635,267	0	4,635,267		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,368,904	0	2,368,904		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,290,981	0	4,290,981		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03020	SLEEP LAB	26,768	0	26,768		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	279,852	0	279,852		90.00
91.00	09100	EMERGENCY	4,464,473	0	4,464,473		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC	0	0	0		99.00
99.10	09910	CORF	0	0	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	1,371,771	0	1,371,771		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	54,456,347	0	54,456,347		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	206,534	0	206,534		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	651,826	0	651,826		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	RENTED SPACE	176,961	0	176,961		194.01
194.02	07952	FOUNDATION	17,260	0	17,260		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	55,508,928	0	55,508,928		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part II Date/Time Prepared: 9/25/2013 9:09 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	9,895	1,264	11,159	11,159	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	29,916	637,866	921,165	1,588,947	2,083	5.00
7.00	00700	OPERATION OF PLANT	8,779	420,610	37,267	466,656	223	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	25,085	16,538	41,623	61	8.00
9.00	00900	HOUSEKEEPING	0	1,992	515	2,507	322	9.00
10.00	01000	DIETARY	0	47,757	20,396	68,153	73	10.00
11.00	01100	CAFETERIA	0	13,358	0	13,358	216	11.00
13.00	01300	NURSING ADMINISTRATION	0	30,280	55,474	85,754	381	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,150	34,767	66,809	108,726	31	14.00
15.00	01500	PHARMACY	184,394	11,500	13,830	209,724	350	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,736	18,298	47,034	281	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,973	235,196	60,969	321,138	2,295	30.00
31.00	03100	INTENSIVE CARE UNIT	11,033	26,650	9,278	46,961	539	31.00
43.00	04300	NURSERY	0	6,927	7,981	14,908	94	43.00
44.00	04400	SKILLED NURSING FACILITY	0	3,751	8,688	12,439	10	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,500	136,947	309,560	461,007	927	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	22,465	22,788	45,253	268	52.00
53.00	05300	ANESTHESIOLOGY	0	2,333	75,120	77,453	15	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,701	104,648	425,761	537,110	523	54.00
56.00	05600	RADIOISOTOPE	0	5,850	2,882	8,732	59	56.00
57.00	05700	CT SCAN	0	5,148	4,041	9,189	105	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,935	13,586	51,573	70,094	65	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	5,115	27,881	32,996	120	59.00
60.00	06000	LABORATORY	0	40,242	64,111	104,353	447	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	1,310	1,310	21	63.00
65.00	06500	RESPIRATORY THERAPY	2,824	10,203	25,746	38,773	161	65.00
66.00	06600	PHYSICAL THERAPY	0	23,086	2,828	25,914	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,323	58	3,381	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,356	0	12,356	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	40,557	72,562	113,119	192	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	0	4,948	0	4,948	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	13,512	2,185	15,697	50	90.00
91.00	09100	EMERGENCY	0	98,370	17,978	116,348	1,008	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	5,833	13,372	693	19,898	231	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	301,038	2,090,431	2,345,549	4,737,018	11,151	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	33,256	1,446	34,702	8	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	122,265	109	122,374	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	RENTED SPACE	0	33,918	0	33,918	0	194.01
194.02	07952	FOUNDATION	0	3,316	0	3,316	0	194.02
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)	301,038	2,283,186	2,347,104	4,931,328	11,159	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part II | Date/Time Prepared: 9/25/2013 9:09 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,591,030					5.00
7.00	00700	OPERATION OF PLANT	89,763	556,642				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,671	11,494	64,849			8.00
9.00	00900	HOUSEKEEPING	45,959	913	816	50,517		9.00
10.00	01000	DIETARY	16,663	21,883	52	2,031	108,855	10.00
11.00	01100	CAFETERIA	27,136	6,121	0	568	0	11.00
13.00	01300	NURSING ADMINISTRATION	43,543	13,875	0	1,288	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,327	15,930	205	1,479	0	14.00
15.00	01500	PHARMACY	47,806	5,269	0	489	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	35,038	13,167	0	1,222	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	253,478	107,770	20,484	10,002	100,474	30.00
31.00	03100	INTENSIVE CARE UNIT	58,989	12,211	9,624	1,133	8,130	31.00
43.00	04300	NURSERY	10,427	3,174	1,093	295	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,529	1,719	2,950	160	251	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	128,877	62,751	8,924	5,825	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,954	10,294	3,121	955	0	52.00
53.00	05300	ANESTHESIOLOGY	7,679	1,069	0	99	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	92,770	47,951	4,955	4,451	0	54.00
56.00	05600	RADIOISOTOPE	19,562	2,681	0	249	0	56.00
57.00	05700	CT SCAN	23,337	2,359	0	219	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,749	6,225	414	578	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	14,379	2,344	0	218	0	59.00
60.00	06000	LABORATORY	92,511	18,440	19	1,712	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	23,528	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	19,057	4,675	0	434	0	65.00
66.00	06600	PHYSICAL THERAPY	20,239	10,578	979	982	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,608	1,523	0	141	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,130	5,661	0	526	0	68.00
69.00	06900	ELECTROCARDIOLOGY	24,868	18,584	124	1,725	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	125,709	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,245	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73,731	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	184	2,267	121	210	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,109	6,191	0	575	0	90.00
91.00	09100	EMERGENCY	110,501	45,074	8,802	4,184	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	37,076	6,127	0	569	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,583,132	468,320	62,683	42,319	108,855	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,100	15,238	0	1,414	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,446	56,023	2,107	5,200	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	RENTED SPACE	1,232	15,541	59	1,443	0	194.01
194.02	07952	FOUNDATION	120	1,520	0	141	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,591,030	556,642	64,849	50,517	108,855	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part II | Date/Time Prepared: 9/25/2013 9:09 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	47,399					11.00
13.00	01300	NURSING ADMINISTRATION	1,668	146,509				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	324	0	134,022			14.00
15.00	01500	PHARMACY	1,418	0	229	265,285		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,331	0	262	0	99,335	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,582	128,269	1,753	66	58,245	30.00
31.00	03100	INTENSIVE CARE UNIT	2,558	10,379	163	97	2,831	31.00
43.00	04300	NURSERY	490	7,143	48	13	4,264	43.00
44.00	04400	SKILLED NURSING FACILITY	132	718	3	0	1,323	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,056	0	1,737	263	20,948	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,396	0	136	38	0	52.00
53.00	05300	ANESTHESIOLOGY	1,413	0	218	2,371	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,362	0	513	341	0	54.00
56.00	05600	RADIOISOTOPE	245	0	5	258	0	56.00
57.00	05700	CT SCAN	525	0	7	14	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	448	0	40	164	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	528	0	36	0	0	59.00
60.00	06000	LABORATORY	2,897	0	683	99	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	139	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,070	0	130	47	8,013	65.00
66.00	06600	PHYSICAL THERAPY	0	0	80	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,100	0	118	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	83,402	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	42,622	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	261,450	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	0	0	3	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	631	0	68	0	0	90.00
91.00	09100	EMERGENCY	4,808	0	1,585	0	3,711	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	1,172	0	151	64	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,293	146,509	133,992	265,285	99,335	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	106	0	30	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	RENTED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	47,399	146,509	134,022	265,285	99,335	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part II | Date/Time Prepared: 9/25/2013 9:09 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,017,556	0	1,017,556		30.00
31.00	03100	INTENSIVE CARE UNIT	153,615	0	153,615		31.00
43.00	04300	NURSERY	41,949	0	41,949		43.00
44.00	04400	SKILLED NURSING FACILITY	21,234	0	21,234		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	696,315	0	696,315		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	91,415	0	91,415		52.00
53.00	05300	ANESTHESIOLOGY	90,317	0	90,317		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	691,976	0	691,976		54.00
56.00	05600	RADIOISOTOPE	31,791	0	31,791		56.00
57.00	05700	CT SCAN	35,755	0	35,755		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	87,777	0	87,777		58.00
59.00	05900	CARDIAC CATHETERIZATION	50,621	0	50,621		59.00
60.00	06000	LABORATORY	221,161	0	221,161		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	24,998	0	24,998		63.00
65.00	06500	RESPIRATORY THERAPY	72,360	0	72,360		65.00
66.00	06600	PHYSICAL THERAPY	58,772	0	58,772		66.00
67.00	06700	OCCUPATIONAL THERAPY	8,653	0	8,653		67.00
68.00	06800	SPEECH PATHOLOGY	24,673	0	24,673		68.00
69.00	06900	ELECTROCARDIOLOGY	159,830	0	159,830		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	209,111	0	209,111		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	106,867	0	106,867		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	335,181	0	335,181		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03020	SLEEP LAB	7,733	0	7,733		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	29,321	0	29,321		90.00
91.00	09100	EMERGENCY	296,021	0	296,021		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC	0	0	0		99.00
99.10	09910	CORF	0	0	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	65,288	0	65,288		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,630,290	0	4,630,290		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	53,598	0	53,598		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	190,150	0	190,150		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	RENTED SPACE	52,193	0	52,193		194.01
194.02	07952	FOUNDATION	5,097	0	5,097		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	4,931,328	0	4,931,328		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B-1 | Date/Time Prepared: 9/25/2013 9:09 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	341,493					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,298,328				2.00
4.00	00400	EMPLOYEE BENEFITS	1,480	1,238	25,392,002			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	95,405	902,021	4,744,769	-11,714,086	43,794,842	5.00
7.00	00700	OPERATION OF PLANT	62,910	36,493	507,561	0	2,470,838	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,752	16,194	138,335	0	321,262	8.00
9.00	00900	HOUSEKEEPING	298	504	733,994	0	1,265,072	9.00
10.00	01000	DIETARY	7,143	19,972	167,144	0	458,680	10.00
11.00	01100	CAFETERIA	1,998	0	492,212	0	746,950	11.00
13.00	01300	NURSING ADMINISTRATION	4,529	54,321	868,681	0	1,198,567	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,200	65,421	70,293	0	201,672	14.00
15.00	01500	PHARMACY	1,720	13,543	796,659	0	1,315,924	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,298	17,918	640,488	0	964,451	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,178	59,702	5,196,500	0	6,977,110	30.00
31.00	03100	INTENSIVE CARE UNIT	3,986	9,085	1,228,802	0	1,623,753	31.00
43.00	04300	NURSERY	1,036	7,815	213,479	0	287,011	43.00
44.00	04400	SKILLED NURSING FACILITY	561	8,507	21,662	0	42,100	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,483	303,127	2,112,049	0	3,547,504	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,360	22,314	609,581	0	824,507	52.00
53.00	05300	ANESTHESIOLOGY	349	73,559	34,072	0	211,361	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,652	416,913	1,192,100	0	2,553,603	54.00
56.00	05600	RADIOISOTOPE	875	2,822	135,416	0	538,470	56.00
57.00	05700	CT SCAN	770	3,957	239,272	0	642,381	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,032	50,501	149,173	0	268,359	58.00
59.00	05900	CARDIAC CATHETERIZATION	765	27,302	273,774	0	395,787	59.00
60.00	06000	LABORATORY	6,019	62,779	1,019,086	0	2,546,484	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,283	48,581	0	647,629	63.00
65.00	06500	RESPIRATORY THERAPY	1,526	25,211	365,668	0	524,557	65.00
66.00	06600	PHYSICAL THERAPY	3,453	2,769	0	0	557,091	66.00
67.00	06700	OCCUPATIONAL THERAPY	497	57	0	0	99,306	67.00
68.00	06800	SPEECH PATHOLOGY	1,848	0	0	0	168,734	68.00
69.00	06900	ELECTROCARDIOLOGY	6,066	71,054	437,747	0	684,533	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,460,295	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,768,421	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,029,549	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	740	0	0	0	5,052	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,021	2,140	114,835	0	168,170	90.00
91.00	09100	EMERGENCY	14,713	17,604	2,296,939	0	3,041,681	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	2,000	679	525,468	0	1,020,562	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	312,663	2,296,805	25,374,340	-11,714,086	43,577,426	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,974	1,416	17,662	0	57,808	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,287	107	0	0	122,374	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	RENTED SPACE	5,073	0	0	0	33,918	194.01
194.02	07952	FOUNDATION	496	0	0	0	3,316	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,283,186	2,347,104	5,825,958		11,714,086	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.685894	1.021222	0.229441		0.267476	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			11,159		1,591,030	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000439		0.036329	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B-1 | Date/Time Prepared: 9/25/2013 9:09 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	181,698					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,752	708,127				8.00
9.00	00900	HOUSEKEEPING	298	8,908	177,648			9.00
10.00	01000	DIETARY	7,143	565	7,143	66,330		10.00
11.00	01100	CAFETERIA	1,998	0	1,998	0	36,598	11.00
13.00	01300	NURSING ADMINISTRATION	4,529	0	4,529	0	1,288	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,200	2,235	5,200	0	250	14.00
15.00	01500	PHARMACY	1,720	0	1,720	0	1,095	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,298	0	4,298	0	1,800	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,178	223,697	35,178	61,223	10,488	30.00
31.00	03100	INTENSIVE CARE UNIT	3,986	105,090	3,986	4,954	1,975	31.00
43.00	04300	NURSERY	1,036	11,934	1,036	0	378	43.00
44.00	04400	SKILLED NURSING FACILITY	561	32,218	561	153	102	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,483	97,447	20,483	0	3,904	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,360	34,077	3,360	0	1,078	52.00
53.00	05300	ANESTHESIOLOGY	349	0	349	0	1,091	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,652	54,106	15,652	0	2,596	54.00
56.00	05600	RADIOISOTOPE	875	0	875	0	189	56.00
57.00	05700	CT SCAN	770	0	770	0	405	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,032	4,523	2,032	0	346	58.00
59.00	05900	CARDIAC CATHETERIZATION	765	0	765	0	408	59.00
60.00	06000	LABORATORY	6,019	212	6,019	0	2,237	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	107	63.00
65.00	06500	RESPIRATORY THERAPY	1,526	0	1,526	0	826	65.00
66.00	06600	PHYSICAL THERAPY	3,453	10,687	3,453	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	497	0	497	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,848	0	1,848	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,066	1,349	6,066	0	849	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	740	1,318	740	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,021	0	2,021	0	487	90.00
91.00	09100	EMERGENCY	14,713	96,114	14,713	0	3,712	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	2,000	0	2,000	0	905	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	152,868	684,480	148,818	66,330	36,516	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,974	0	4,974	0	82	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,287	23,004	18,287	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	RENTED SPACE	5,073	643	5,073	0	0	194.01
194.02	07952	FOUNDATION	496	0	496	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,131,728	471,861	1,614,520	769,776	999,336	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.235897	0.666351	9.088309	11.605246	27.305754	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	556,642	64,849	50,517	108,855	47,399	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.063556	0.091578	0.284366	1.641113	1.295125	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B-1 | Date/Time Prepared: 9/25/2013 9:09 am

		Cost Center Description	NURSING ADMINISTRATION (PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	18,153					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,560,503				14.00
15.00	01500	PHARMACY	0	9,513	2,062,674			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,882	0	29,443		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,893	72,720	510	17,264		30.00
31.00	03100	INTENSIVE CARE UNIT	1,286	6,776	754	839		31.00
43.00	04300	NURSERY	885	1,973	102	1,264		43.00
44.00	04400	SKILLED NURSING FACILITY	89	105	0	392		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	72,075	2,043	6,209		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,636	292	0		52.00
53.00	05300	ANESTHESIOLOGY	0	9,037	18,433	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,282	2,650	0		54.00
56.00	05600	RADIOISOTOPE	0	189	2,003	0		56.00
57.00	05700	CT SCAN	0	287	106	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,660	1,272	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,493	0	0		59.00
60.00	06000	LABORATORY	0	28,357	772	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	5,397	365	2,375		65.00
66.00	06600	PHYSICAL THERAPY	0	3,338	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,903	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,460,295	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,768,421	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,032,876	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
76.00	03020	SLEEP LAB	0	104	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,806	0	0		90.00
91.00	09100	EMERGENCY	0	65,746	0	1,100		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0		99.00
99.10	09910	CORF	0	0	0	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	6,278	496	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,153	5,559,273	2,062,674	29,443		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,230	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.01	07951	RENTED SPACE	0	0	0	0		194.01
194.02	07952	FOUNDATION	0	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,673,547	400,815	1,743,766	1,385,494		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	92.191208	0.072083	0.845391	47.056822		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	146,509	134,022	265,285	99,335		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.070787	0.024102	0.128612	3.373807		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet C Part I Date/Time Prepared: 9/25/2013 9:09 am

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	03000	ADULTS & PEDIATRICS	13,198,575		13,198,575	0	13,198,575	30.00
31.00	03100	INTENSIVE CARE UNIT	2,503,608		2,503,608	0	2,503,608	31.00
43.00	04300	NURSERY	550,622		550,622	0	550,622	43.00
44.00	04400	SKILLED NURSING FACILITY	120,817		120,817	0	120,817	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,506,209		5,506,209	0	5,506,209	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,186,289		1,186,289	0	1,186,289	52.00
53.00	05300	ANESTHESIOLOGY	323,107		323,107	0	323,107	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,759,371		3,759,371	0	3,759,371	54.00
56.00	05600	RADIOISOTOPE	712,399		712,399	0	712,399	56.00
57.00	05700	CT SCAN	845,643		845,643	0	845,643	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	407,286		407,286	0	407,286	58.00
59.00	05900	CARDIAC CATHETERIZATION	533,038		533,038	0	533,038	59.00
60.00	06000	LABORATORY	3,449,974		3,449,974	0	3,449,974	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	823,776		823,776	0	823,776	63.00
65.00	06500	RESPIRATORY THERAPY	840,047	0	840,047	0	840,047	65.00
66.00	06600	PHYSICAL THERAPY	804,359	0	804,359	0	804,359	66.00
67.00	06700	OCCUPATIONAL THERAPY	138,951	0	138,951	0	138,951	67.00
68.00	06800	SPEECH PATHOLOGY	262,513	0	262,513	0	262,513	68.00
69.00	06900	ELECTROCARDIOLOGY	1,051,747		1,051,747	0	1,051,747	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,635,267		4,635,267	0	4,635,267	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,368,904		2,368,904	0	2,368,904	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,290,981		4,290,981	0	4,290,981	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
76.00	03020	SLEEP LAB	26,768		26,768	0	26,768	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	279,852		279,852	0	279,852	90.00
91.00	09100	EMERGENCY	4,464,473		4,464,473	0	4,464,473	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,146,476		2,146,476		2,146,476	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0		0		0	99.00
99.10	09910	CORF	0		0		0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0		0		0	100.00
101.00	10100	HOME HEALTH AGENCY	1,371,771		1,371,771		1,371,771	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	56,602,823	0	56,602,823	0	56,602,823	200.00
201.00		Less Observation Beds	2,146,476		2,146,476		2,146,476	201.00
202.00		Total (see instructions)	54,456,347	0	54,456,347	0	54,456,347	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet C Part I Date/Time Prepared: 9/25/2013 9:09 am

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	03000	ADULTS & PEDIATRICS	19,063,764		19,063,764			30.00
31.00	03100	INTENSIVE CARE UNIT	3,415,454		3,415,454			31.00
43.00	04300	NURSERY	785,087		785,087			43.00
44.00	04400	SKILLED NURSING FACILITY	39,353		39,353			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,432,075	26,481,255	36,913,330	0.149166	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,010,078	231,958	2,242,036	0.529112	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,394,519	2,567,242	3,961,761	0.081556	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,319,202	14,227,509	17,546,711	0.214249	0.000000	54.00
56.00	05600	RADIOISOTOPE	1,066,116	5,684,919	6,751,035	0.105524	0.000000	56.00
57.00	05700	CT SCAN	3,962,695	17,471,078	21,433,773	0.039454	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	339,966	4,911,504	5,251,470	0.077557	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,097,407	2,116,632	3,214,039	0.165847	0.000000	59.00
60.00	06000	LABORATORY	9,361,829	17,410,473	26,772,302	0.128864	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	885,780	390,482	1,276,262	0.645460	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	3,460,782	334,288	3,795,070	0.221352	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,281,261	1,238,897	2,520,158	0.319170	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	176,626	187,263	363,889	0.381850	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	127,196	121,695	248,891	1.054731	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,680,787	7,195,042	9,875,829	0.106497	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,032,222	3,704,196	10,736,418	0.431733	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,035,307	1,189,701	5,225,008	0.453378	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,660,286	8,237,119	22,897,405	0.187400	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03020	SLEEP LAB	6,302	1,476,912	1,483,214	0.018047	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	291	1,245,628	1,245,919	0.224615	0.000000	90.00
91.00	09100	EMERGENCY	4,443,616	24,626,419	29,070,035	0.153576	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	305,496	3,246,773	3,552,269	0.604255	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0			100.00
101.00	10100	HOME HEALTH AGENCY	0	1,628,087	1,628,087			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	95,383,497	145,925,072	241,308,569			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	95,383,497	145,925,072	241,308,569			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet C Part I Date/Time Prepared: 9/25/2013 9:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.149166	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.529112	52.00
53.00	05300	ANESTHESIOLOGY	0.081556	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.214249	54.00
56.00	05600	RADIOISOTOPE	0.105524	56.00
57.00	05700	CT SCAN	0.039454	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.077557	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.165847	59.00
60.00	06000	LABORATORY	0.128864	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.645460	63.00
65.00	06500	RESPIRATORY THERAPY	0.221352	65.00
66.00	06600	PHYSICAL THERAPY	0.319170	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.381850	67.00
68.00	06800	SPEECH PATHOLOGY	1.054731	68.00
69.00	06900	ELECTROCARDIOLOGY	0.106497	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.431733	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.453378	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187400	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03020	SLEEP LAB	0.018047	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.224615	90.00
91.00	09100	EMERGENCY	0.153576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.604255	92.00
		OTHER REIMBURSABLE COST CENTERS		
99.00	09900	CMHC		99.00
99.10	09910	CORF		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM		100.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part I Date/Time Prepared: 9/25/2013 9:09 am

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	1,017,556	0	1,017,556	15,809	64.37	30.00
31.00	INTENSIVE CARE UNIT	153,615		153,615	1,286	119.45	31.00
43.00	NURSERY	41,949		41,949	885	47.40	43.00
44.00	SKILLED NURSING FACILITY	21,234		21,234	89	238.58	44.00
200.00	Total (lines 30-199)	1,234,354		1,234,354	18,069		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	7,915	509,489	30.00
31.00	INTENSIVE CARE UNIT	697	83,257	31.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	89	21,234	44.00
200.00	Total (lines 30-199)	8,701	613,980	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part II Date/Time Prepared: 9/25/2013 9:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	696,315	36,913,330	0.018864	4,955,658	93,484	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	91,415	2,242,036	0.040773	30,599	1,248	52.00
53.00	05300	ANESTHESIOLOGY	90,317	3,961,761	0.022797	539,855	12,307	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	691,976	17,546,711	0.039436	2,041,931	80,526	54.00
56.00	05600	RADIOISOTOPE	31,791	6,751,035	0.004709	655,908	3,089	56.00
57.00	05700	CT SCAN	35,755	21,433,773	0.001668	2,187,335	3,648	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	87,777	5,251,470	0.016715	196,350	3,282	58.00
59.00	05900	CARDIAC CATHETERIZATION	50,621	3,214,039	0.015750	557,755	8,785	59.00
60.00	06000	LABORATORY	221,161	26,772,302	0.008261	5,441,909	44,956	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	24,998	1,276,262	0.019587	621,962	12,182	63.00
65.00	06500	RESPIRATORY THERAPY	72,360	3,795,070	0.019067	2,221,426	42,356	65.00
66.00	06600	PHYSICAL THERAPY	58,772	2,520,158	0.023321	864,414	20,159	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,653	363,889	0.023779	105,220	2,502	67.00
68.00	06800	SPEECH PATHOLOGY	24,673	248,891	0.099132	102,025	10,114	68.00
69.00	06900	ELECTROCARDIOLOGY	159,830	9,875,829	0.016184	1,730,130	28,000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	209,111	10,736,418	0.019477	4,256,234	82,899	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	106,867	5,225,008	0.020453	1,935,222	39,581	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	335,181	22,897,405	0.014638	8,591,971	125,769	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03020	SLEEP LAB	7,733	1,483,214	0.005214	6,302	33	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	29,321	1,245,919	0.023534	291	7	90.00
91.00	09100	EMERGENCY	296,021	29,070,035	0.010183	2,678,488	27,275	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	165,485	3,552,269	0.046586	211,071	9,833	92.00
200.00		Total (lines 50-199)	3,496,133	216,376,824		39,932,056	652,035	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part III Date/Time Prepared: 9/25/2013 9:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,809	0.00	7,915	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,286	0.00	697	0		31.00
43.00	04300	NURSERY	885	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	89	0.00	89	0		44.00
200.00		Total (lines 30-199)	18,069		8,701	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV Date/Time Prepared: 9/25/2013 9:09 am

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	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV Date/Time Prepared: 9/25/2013 9:09 am

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	05000	OPERATING ROOM	0	36,913,330	0.000000	0.000000	4,955,658	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,242,036	0.000000	0.000000	30,599	52.00
53.00	05300	ANESTHESIOLOGY	0	3,961,761	0.000000	0.000000	539,855	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,546,711	0.000000	0.000000	2,041,931	54.00
56.00	05600	RADIOISOTOPE	0	6,751,035	0.000000	0.000000	655,908	56.00
57.00	05700	CT SCAN	0	21,433,773	0.000000	0.000000	2,187,335	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,251,470	0.000000	0.000000	196,350	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,214,039	0.000000	0.000000	557,755	59.00
60.00	06000	LABORATORY	0	26,772,302	0.000000	0.000000	5,441,909	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,276,262	0.000000	0.000000	621,962	63.00
65.00	06500	RESPIRATORY THERAPY	0	3,795,070	0.000000	0.000000	2,221,426	65.00
66.00	06600	PHYSICAL THERAPY	0	2,520,158	0.000000	0.000000	864,414	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	363,889	0.000000	0.000000	105,220	67.00
68.00	06800	SPEECH PATHOLOGY	0	248,891	0.000000	0.000000	102,025	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,875,829	0.000000	0.000000	1,730,130	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,736,418	0.000000	0.000000	4,256,234	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,225,008	0.000000	0.000000	1,935,222	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,897,405	0.000000	0.000000	8,591,971	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03020	SLEEP LAB	0	1,483,214	0.000000	0.000000	6,302	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,245,919	0.000000	0.000000	291	90.00
91.00	09100	EMERGENCY	0	29,070,035	0.000000	0.000000	2,678,488	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,552,269	0.000000	0.000000	211,071	92.00
200.00		Total (lines 50-199)	0	216,376,824			39,932,056	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV Date/Time Prepared: 9/25/2013 9:09 am

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)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	6,807,126	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	791,728	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,680,188	0		54.00
56.00	05600	RADIOISOTOPE	0	2,156,924	0		56.00
57.00	05700	CT SCAN	0	6,555,577	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,349,739	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	831,985	0		59.00
60.00	06000	LABORATORY	0	451,191	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	278,073	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	153,329	0		65.00
66.00	06600	PHYSICAL THERAPY	0	4,813	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,949,437	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,118,684	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	555,938	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,826,985	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03020	SLEEP LAB	0	364,622	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	85,923	0		90.00
91.00	09100	EMERGENCY	0	4,487,867	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	943,278	0		92.00
200.00		Total (lines 50-199)	0	36,393,407	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part V Date/Time Prepared: 9/25/2013 9:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.149166	6,807,126	0	0	1,015,392	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.529112	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.081556	791,728	0	0	64,570	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.214249	3,680,188	0	0	788,477	54.00
56.00	05600	RADIOISOTOPE	0.105524	2,156,924	0	0	227,607	56.00
57.00	05700	CT SCAN	0.039454	6,555,577	0	0	258,644	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.077557	1,349,739	0	0	104,682	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.165847	831,985	0	0	137,982	59.00
60.00	06000	LABORATORY	0.128864	451,191	1,248	0	58,142	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.645460	278,073	0	0	179,485	63.00
65.00	06500	RESPIRATORY THERAPY	0.221352	153,329	0	0	33,940	65.00
66.00	06600	PHYSICAL THERAPY	0.319170	4,813	0	0	1,536	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.381850	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.054731	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.106497	2,949,437	0	0	314,106	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.431733	1,118,684	0	0	482,973	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.453378	555,938	38,125	0	252,050	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187400	2,826,985	0	0	529,777	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03020	SLEEP LAB	0.018047	364,622	0	0	6,580	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.224615	85,923	0	0	19,300	90.00
91.00	09100	EMERGENCY	0.153576	4,487,867	0	0	689,229	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.604255	943,278	0	0	569,980	92.00
200.00		Subtotal (see instructions)		36,393,407	39,373	0	5,734,452	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		36,393,407	39,373	0	5,734,452	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part V Date/Time Prepared: 9/25/2013 9:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	161	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,285	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	SLEEP LAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	17,446	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	17,446	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140120 | Component CCN: 145766 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV | Date/Time Prepared: 9/25/2013 9:09 am

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	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140120 | Component CCN: 145766 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV Date/Time Prepared: 9/25/2013 9:09 am

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	05000	OPERATING ROOM	0	36,913,330	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,242,036	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,961,761	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,546,711	0.000000	0.000000	1,981	54.00
56.00	05600	RADIOISOTOPE	0	6,751,035	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	21,433,773	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,251,470	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,214,039	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	26,772,302	0.000000	0.000000	7,558	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,276,262	0.000000	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	3,795,070	0.000000	0.000000	10,317	65.00
66.00	06600	PHYSICAL THERAPY	0	2,520,158	0.000000	0.000000	19,637	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	363,889	0.000000	0.000000	19,595	67.00
68.00	06800	SPEECH PATHOLOGY	0	248,891	0.000000	0.000000	445	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,875,829	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,736,418	0.000000	0.000000	12,650	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,225,008	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,897,405	0.000000	0.000000	28,203	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03020	SLEEP LAB	0	1,483,214	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,245,919	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	29,070,035	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,552,269	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	216,376,824			100,386	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140120 | Component CCN: 145766 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV | Date/Time Prepared: 9/25/2013 9:09 am

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)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03020	SLEEP LAB	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140120	Period: From 05/01/2012 To 04/30/2013	Worksheet D-1 Date/Time Prepared: 9/25/2013 9:09 am
	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)	15,809	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,809	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	13,238	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)	7,915	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)	13,198,575	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)	13,198,575	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	20,505,095	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	20,505,095	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.643673	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)	1,548.96	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)	13,198,575	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)	834.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,608,075	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)	6,608,075	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-1 | Date/Time Prepared: 9/25/2013 9:09 am

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	2,503,608	1,286	1,946.82	697	1,356,934	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)	8,566,680	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	16,531,689	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)	592,746	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	652,035	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,244,781	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	15,286,908	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)	2,571	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	834.88	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,146,476	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-1 | Date/Time Prepared: 9/25/2013 9:09 am

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	1,017,556	13,198,575	0.077096	2,146,476	165,485	90.00
91.00	Nursing School cost	0	13,198,575	0.000000	2,146,476	0	91.00
92.00	Allied health cost	0	13,198,575	0.000000	2,146,476	0	92.00
93.00	All other Medical Education	0	13,198,575	0.000000	2,146,476	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140120 Component CCN: 145766	Period: From 05/01/2012 To 04/30/2013	Worksheet D-1 Date/Time Prepared: 9/25/2013 9:09 am
	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)	89	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	89	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	89	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)	89	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)	120,817	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)	120,817	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	39,353	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	39,353	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	3.070084	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)	442.17	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)	120,817	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: 140120 | Component CCN: 145766 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-1 | Date/Time Prepared: 9/25/2013 9:09 am

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)	120,817	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	1,357.49	71.00
72.00	Program routine service cost (line 9 x line 71)	120,817	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)	120,817	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)	120,817	83.00
84.00	Program inpatient ancillary services (see instructions)	28,647	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)	149,464	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: 140120 Component CCN: 145766	Period: From 05/01/2012 To 04/30/2013	Worksheet D-1 Date/Time Prepared: 9/25/2013 9:09 am
	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: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-3 | Date/Time Prepared: 9/25/2013 9:09 am

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	03000	ADULTS & PEDIATRICS		11,258,422		30.00
31.00	03100	INTENSIVE CARE UNIT		1,799,083		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.149166	4,955,658	739,216	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.529112	30,599	16,190	52.00
53.00	05300	ANESTHESIOLOGY	0.081556	539,855	44,028	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.214249	2,041,931	437,482	54.00
56.00	05600	RADIOISOTOPE	0.105524	655,908	69,214	56.00
57.00	05700	CT SCAN	0.039454	2,187,335	86,299	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.077557	196,350	15,228	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.165847	557,755	92,502	59.00
60.00	06000	LABORATORY	0.128864	5,441,909	701,266	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.645460	621,962	401,452	63.00
65.00	06500	RESPIRATORY THERAPY	0.221352	2,221,426	491,717	65.00
66.00	06600	PHYSICAL THERAPY	0.319170	864,414	275,895	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.381850	105,220	40,178	67.00
68.00	06800	SPEECH PATHOLOGY	1.054731	102,025	107,609	68.00
69.00	06900	ELECTROCARDIOLOGY	0.106497	1,730,130	184,254	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.431733	4,256,234	1,837,557	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.453378	1,935,222	877,387	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187400	8,591,971	1,610,135	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03020	SLEEP LAB	0.018047	6,302	114	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.224615	291	65	90.00
91.00	09100	EMERGENCY	0.153576	2,678,488	411,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.604255	211,071	127,541	92.00
200.00		Total (sum of lines 50-94 and 96-98)		39,932,056	8,566,680	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)		39,932,056		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140120 | Component CCN: 145766 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-3 | Date/Time Prepared: 9/25/2013 9:09 am

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	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.149166	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.529112	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.081556	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.214249	1,981	424	54.00
56.00	05600	RADIOISOTOPE	0.105524	0	0	56.00
57.00	05700	CT SCAN	0.039454	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.077557	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.165847	0	0	59.00
60.00	06000	LABORATORY	0.128864	7,558	974	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.645460	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.221352	10,317	2,284	65.00
66.00	06600	PHYSICAL THERAPY	0.319170	19,637	6,268	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.381850	19,595	7,482	67.00
68.00	06800	SPEECH PATHOLOGY	1.054731	445	469	68.00
69.00	06900	ELECTROCARDIOLOGY	0.106497	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.431733	12,650	5,461	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.453378	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187400	28,203	5,285	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03020	SLEEP LAB	0.018047	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.224615	0	0	90.00
91.00	09100	EMERGENCY	0.153576	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.604255	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		100,386	28,647	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)		100,386		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet E Part A Date/Time Prepared: 9/25/2013 9:09 am

Title XVIII | Hospital | PPS

		before 1/1	on/after 1/1	
		1.00	1.01	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS			
1.00	DRG Amounts Other than Outlier Payments	9,986,785		1.00
2.00	Outlier payments for discharges. (see instructions)	377,177		2.00
2.01	Outlier reconciliation amount	0		2.01
3.00	Managed Care Simulated Payments	0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	90.96		4.00
	Indirect Medical Education Adjustment			
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.	0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00		11.00
12.00	Current year allowable FTE (see instructions)	0.00		12.00
13.00	Total allowable FTE count for the prior year.	0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00		15.00
16.00	Adjustment for residents in initial years of the program	0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure	0.00		17.00
18.00	Adjusted rolling average FTE count	0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000		21.00
22.00	IME payment adjustment (see instructions)	0		22.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA			
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000		26.00
27.00	IME payments adjustment. (see instructions)	0.000000		27.00
28.00	IME Adjustment (see instructions)	0		28.00
29.00	Total IME payment (sum of lines 22 and 28)	0		29.00
	Disproportionate Share Adjustment			
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.75		30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)	17.32		31.00
32.00	Sum of lines 30 and 31	20.07		32.00
33.00	Allowable disproportionate share percentage (see instructions)	5.80		33.00
34.00	Disproportionate share adjustment (see instructions)	579,234		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)	10,943,196		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140120	Period: From 05/01/2012 To 04/30/2013	Worksheet E Part A Date/Time Prepared: 9/25/2013 9:09 am
	Title XVIII	Hospital	PPS

		before 1/1	on/after 1/1	
		1.00	1.01	
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	10,943,196		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	824,159		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)	0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).	0		52.00
53.00	Nursing and Allied Health Managed Care payment	0		53.00
54.00	Special add-on payments for new technologies	0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)	0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)	0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).	0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	0		58.00
59.00	Total (sum of amounts on lines 49 through 58)	11,767,355		59.00
60.00	Primary payer payments	2,787		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	11,764,568		61.00
62.00	Deductibles billed to program beneficiaries	1,365,976		62.00
63.00	Coinsurance billed to program beneficiaries	49,191		63.00
64.00	Allowable bad debts (see instructions)	239,606		64.00
65.00	Adjusted reimbursable bad debts (see instructions)	167,724		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	196,067		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	10,517,125		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)	0		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96).(For SCH see instructions)	0		69.00
70.00	SEQUESTRATION	-17,235		70.00
70.93	HVBP incentive payment (see instructions)	3,545		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)	-35,996		70.94
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)	10,467,439		71.00
72.00	Interim payments	10,405,186		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)	62,253		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	21,968		75.00
	TO BE COMPLETED BY CONTRACTOR			
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)	0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2	0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)	0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)	0		93.00
94.00	The rate used to calculate the Time Value of Money	0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)	0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)	0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140120	Period: From 05/01/2012 To 04/30/2013	Worksheet E Part B Date/Time Prepared: 9/25/2013 9:09 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	17,446	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	5,734,452	2.00
3.00	PPS payments	5,380,088	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)	17,446	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	39,373	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)	39,373	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)	39,373	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	21,927	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)	17,446	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)	5,380,088	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	7,625	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,364,805	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	4,025,104	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	4,025,104	30.00
31.00	Primary payer payments	508	31.00
32.00	Subtotal (line 30 minus line 31)	4,024,596	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)	219,836	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	153,885	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	182,745	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	4,178,481	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	SEQUESTRATION	-6,869	39.00
39.98	AB Re-billing demo amount (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	4,171,612	40.00
41.00	Interim payments	4,113,039	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)	58,573	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 9/25/2013 9:09 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		10,432,270		4,109,329	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	10/17/2012	3,710	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	10/17/2012	27,084		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)		-27,084		3,710	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)		10,405,186		4,113,039	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		62,253		58,573	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		10,467,439		4,171,612	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: 140120 | Component CCN: 145766 | Period: From 05/01/2012 To 04/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 9/25/2013 9:09 am

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		31,640		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)		31,640		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		31,640		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: 140120	Period: From 05/01/2012 To 04/30/2013	Worksheet E-1 Part II Date/Time Prepared: 9/25/2013 9:09 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	3,447	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	8,612	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	1,624	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	14,524	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	241,308,569	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	5,747,742	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1,775,743	8.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	1,700,320	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)	75,423	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140120 Component CCN: 145766	Period: From 05/01/2012 To 04/30/2013	Worksheet E-3 Part VI Date/Time Prepared: 9/25/2013 9:09 am
	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)	32,507	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	32,507	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	867	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)	31,640	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	31,640	15.00
16.00	Interim payments	31,640	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)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet G | Date/Time Prepared: 9/25/2013 9:09 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,826,457	0	0	0	1.00
2.00	Temporary investments	500,578	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	14,665,278	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,573,000	0	0	0	6.00
7.00	Inventory	1,025,631	0	0	0	7.00
8.00	Prepaid expenses	2,289,571	0	0	0	8.00
9.00	Other current assets	885,361	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	18,619,876	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,449,581	0	0	0	12.00
13.00	Land improvements	1,827,216	0	0	0	13.00
14.00	Accumulated depreciation	-1,589,307	0	0	0	14.00
15.00	Buildings	11,585,946	0	0	0	15.00
16.00	Accumulated depreciation	-8,477,735	0	0	0	16.00
17.00	Leasehold improvements	18,297,682	0	0	0	17.00
18.00	Accumulated depreciation	-14,577,956	0	0	0	18.00
19.00	Fixed equipment	16,594,503	0	0	0	19.00
20.00	Accumulated depreciation	-11,767,616	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	27,288,147	0	0	0	23.00
24.00	Accumulated depreciation	-19,902,473	0	0	0	24.00
25.00	Minor equipment depreciable	1,428,873	0	0	0	25.00
26.00	Accumulated depreciation	-606,735	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	2,813,004	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	24,363,130	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	26,090,974	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	3,414,374	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	29,505,348	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	72,488,354	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,914,382	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	3,238,284	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	3,753,016	0	0	0	43.00
44.00	Other current liabilities	4,447,162	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,352,844	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	16,909,862	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	7,905,496	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	24,815,358	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	40,168,202	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	32,320,152				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)	32,320,152	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	72,488,354	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet G-1 | Date/Time Prepared: 9/25/2013 9:09 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		29,866,277		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,559,368				2.00
3.00	Total (sum of line 1 and line 2)		35,425,645		0		3.00
4.00	INCREASE IN RESTRICTED ASSETS	19,760		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		19,760		0		10.00
11.00	Subtotal (line 3 plus line 10)		35,445,405		0		11.00
12.00	CHANGES IN MINIMUM PENSION LIABILITY	625,823		0		0	12.00
13.00	TRANSFERS TO AFFILIATES	2,499,430		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		3,125,253		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		32,320,152		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	INCREASE IN RESTRICTED ASSETS		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	CHANGES IN MINIMUM PENSION LIABILITY		0		12.00
13.00	TRANSFERS TO AFFILIATES		0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet G-2 Parts I & II Date/Time Prepared: 9/25/2013 9:09 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	20,124,286		20,124,286	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	39,353		39,353	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)	20,163,639		20,163,639	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,415,454		3,415,454	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,415,454		3,415,454	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	23,579,093		23,579,093	17.00
18.00	Ancillary services	68,200,183	116,624,294	184,824,477	18.00
19.00	Outpatient services	4,749,403	29,323,198	34,072,601	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,628,087	1,628,087	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PROFESSIONAL FEES	3,777,890	4,338,767	8,116,657	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	100,306,569	151,914,346	252,220,915	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		62,795,758		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)		62,795,758		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet G-3 | Date/Time Prepared: 9/25/2013 9:09 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	252,220,915	1.00
2.00	Less contractual allowances and discounts on patients' accounts	190,208,301	2.00
3.00	Net patient revenues (line 1 minus line 2)	62,012,614	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	62,795,758	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-783,144	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	27,225	6.00
7.00	Income from investments	970,217	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	1,670	13.00
14.00	Revenue from meals sold to employees and guests	534,792	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	24,947	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	75,573	22.00
23.00	Governmental appropriations	0	23.00
24.00	EHR INCENTIVE PAYMENTS	2,400,320	24.00
24.01	WELLNESS CENTER	20,588	24.01
24.02	AUTOPSY FEES	1,968	24.02
24.03	NEISS PAYMENTS	4,570	24.03
24.04	MISCELLANEOUS INCOME	100,323	24.04
24.05	UNREALIZED GAIN ON INVESTMENT	2,180,319	24.05
25.00	Total other income (sum of lines 6-24)	6,342,512	25.00
26.00	Total (line 5 plus line 25)	5,559,368	26.00
27.00		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)	5,559,368	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet H

HHA CCN: 147057 | Date/Time Prepared: 9/25/2013 9:09 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		5,833	5,833	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	97,899	0	30,366	487	40,763	169,515	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	351,901	0	0	0	0	351,901	6.00
7.00	Physical Therapy	0	0	0	239,916	0	239,916	7.00
8.00	Occupational Therapy	0	0	0	27,378	0	27,378	8.00
9.00	Speech Pathology	0	0	0	11,374	0	11,374	9.00
10.00	Medical Social Services	78	0	0	0	0	78	10.00
11.00	Home Health Aide	75,590	0	0	0	0	75,590	11.00
12.00	Supplies (see instructions)	0	0	0	3,852	14,479	18,331	12.00
13.00	Drugs	0	0	0	0	496	496	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	525,468	0	30,366	283,007	61,571	900,412	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	5,833	0	5,833			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	169,515	0	169,515			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	351,901	0	351,901			6.00
7.00	Physical Therapy	0	239,916	0	239,916			7.00
8.00	Occupational Therapy	0	27,378	0	27,378			8.00
9.00	Speech Pathology	0	11,374	0	11,374			9.00
10.00	Medical Social Services	0	78	0	78			10.00
11.00	Home Health Aide	0	75,590	0	75,590			11.00
12.00	Supplies (see instructions)	-14,479	3,852	0	3,852			12.00
13.00	Drugs	0	496	0	496			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	-14,479	885,933	0	885,933			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2012 To 04/30/2013 | Worksheet H-1 Part I | Date/Time Prepared: 9/25/2013 9:09 am

Home Health Agency I | PPS

			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	5,833	5,833				0	1.00
2.00	Capital Related - Movable Equipment	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	169,515	5,833	0	0	0	175,348	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	351,901	0	0	0	0	351,901	6.00
7.00	Physical Therapy	239,916	0	0	0	0	239,916	7.00
8.00	Occupational Therapy	27,378	0	0	0	0	27,378	8.00
9.00	Speech Pathology	11,374	0	0	0	0	11,374	9.00
10.00	Medical Social Services	78	0	0	0	0	78	10.00
11.00	Home Health Aide	75,590	0	0	0	0	75,590	11.00
12.00	Supplies (see instructions)	3,852	0	0	0	0	3,852	12.00
13.00	Drugs	496	0	0	0		496	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	885,933	5,833	0	0	0	885,933	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	175,348		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	86,837	438,738	6.00
7.00	Physical Therapy	59,203	299,119	7.00
8.00	Occupational Therapy	6,756	34,134	8.00
9.00	Speech Pathology	2,807	14,181	9.00
10.00	Medical Social Services	19	97	10.00
11.00	Home Health Aide	18,653	94,243	11.00
12.00	Supplies (see instructions)	951	4,803	12.00
13.00	Drugs	122	618	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		885,933	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 140120 HHA CCN: 147057 | Period: From 05/01/2012 To 04/30/2013 | Worksheet H-1 Part II Date/Time Prepared: 9/25/2013 9:09 am

Home Health Agency I | PPS

		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	2,000				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	2,000	0	0	0	-175,348	710,585	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	351,901	6.00
7.00	Physical Therapy	0	0	0	0	0	239,916	7.00
8.00	Occupational Therapy	0	0	0	0	0	27,378	8.00
9.00	Speech Pathology	0	0	0	0	0	11,374	9.00
10.00	Medical Social Services	0	0	0	0	0	78	10.00
11.00	Home Health Aide	0	0	0	0	0	75,590	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	3,852	12.00
13.00	Drugs	0	0	0		0	496	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	2,000	0	0	0	-175,348	710,585	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	5,833	0	0	0		175,348	25.00
26.00	Unit Cost Multiplier	2.916500	0.000000	0.000000	0.000000		0.246766	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140120 HHA CCN: 147057 | Period: From 05/01/2012 To 04/30/2013 | Worksheet H-2 Part I Date/Time Prepared: 9/25/2013 9:09 am

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	13,372	693	22,462	36,527	9,770	1.00
2.00	Skilled Nursing Care	438,738	0	0	80,741	519,479	138,948	2.00
3.00	Physical Therapy	299,119	0	0	0	299,119	80,007	3.00
4.00	Occupational Therapy	34,134	0	0	0	34,134	9,130	4.00
5.00	Speech Pathology	14,181	0	0	0	14,181	3,793	5.00
6.00	Medical Social Services	97	0	0	18	115	31	6.00
7.00	Home Health Aide	94,243	0	0	17,343	111,586	29,847	7.00
8.00	Supplies (see instructions)	4,803	0	0	0	4,803	1,285	8.00
9.00	Drugs	618	0	0	0	618	165	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	885,933	13,372	693	120,564	1,020,562	272,976	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	34,472	0	18,177	0	24,712	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	34,472	0	18,177	0	24,712	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: 140120 HHA CCN: 147057 | Period: From 05/01/2012 To 04/30/2013 | Worksheet H-2 Part I Date/Time Prepared: 9/25/2013 9:09 am

Home Health Agency I | PPS

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	453	419	0	124,530	0	124,530	1.00
2.00	Skilled Nursing Care	0	0	0	658,427	0	658,427	2.00
3.00	Physical Therapy	0	0	0	379,126	0	379,126	3.00
4.00	Occupational Therapy	0	0	0	43,264	0	43,264	4.00
5.00	Speech Pathology	0	0	0	17,974	0	17,974	5.00
6.00	Medical Social Services	0	0	0	146	0	146	6.00
7.00	Home Health Aide	0	0	0	141,433	0	141,433	7.00
8.00	Supplies (see instructions)	0	0	0	6,088	0	6,088	8.00
9.00	Drugs	0	0	0	783	0	783	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	453	419	0	1,371,771	0	1,371,771	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs	
		27.00	28.00	
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	65,740	724,167	2.00
3.00	Physical Therapy	37,853	416,979	3.00
4.00	Occupational Therapy	4,320	47,584	4.00
5.00	Speech Pathology	1,795	19,769	5.00
6.00	Medical Social Services	15	161	6.00
7.00	Home Health Aide	14,121	155,554	7.00
8.00	Supplies (see instructions)	608	6,696	8.00
9.00	Drugs	78	861	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	124,530	1,371,771	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.	0.099844		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: 140120 HHA CCN: 147057 | Period: From 05/01/2012 To 04/30/2013 | Worksheet H-2 Part II Date/Time Prepared: 9/25/2013 9:09 am

Home Health Agency I | PPS

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	2,000	679	97,899	0	36,527	2,000	1.00
2.00	Skilled Nursing Care	0	0	351,901	0	519,479	0	2.00
3.00	Physical Therapy	0	0	0	0	299,119	0	3.00
4.00	Occupational Therapy	0	0	0	0	34,134	0	4.00
5.00	Speech Pathology	0	0	0	0	14,181	0	5.00
6.00	Medical Social Services	0	0	78	0	115	0	6.00
7.00	Home Health Aide	0	0	75,590	0	111,586	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	4,803	0	8.00
9.00	Drugs	0	0	0	0	618	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	2,000	679	525,468		1,020,562	2,000	20.00
21.00	Total cost to be allocated	13,372	693	120,564		272,976	34,472	21.00
22.00	Unit cost multiplier	6.686000	1.020619	0.229441		0.267476	17.236000	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	NURSING ADMINISTRATION (PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	2,000	0	905	0	6,278	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	2,000	0	905	0	6,278	20.00
21.00	Total cost to be allocated	0	18,177	0	24,712	0	453	21.00
22.00	Unit cost multiplier	0.000000	9.088500	0.000000	27.306077	0.000000	0.072157	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140120 HHA CCN: 147057

Period: From 05/01/2012 To 04/30/2013

Worksheet H-2 Part II Date/Time Prepared: 9/25/2013 9:09 am

Home Health Agency I

PPS

	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)			
		15.00	16.00			
1.00	Administrative and General	496	0			1.00
2.00	Skilled Nursing Care	0	0			2.00
3.00	Physical Therapy	0	0			3.00
4.00	Occupational Therapy	0	0			4.00
5.00	Speech Pathology	0	0			5.00
6.00	Medical Social Services	0	0			6.00
7.00	Home Health Aide	0	0			7.00
8.00	Supplies (see instructions)	0	0			8.00
9.00	Drugs	0	0			9.00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11.00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	0			13.00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15.00
16.00	Day Care Program	0	0			16.00
17.00	Home Delivered Meals Program	0	0			17.00
18.00	Homemaker Service	0	0			18.00
19.00	All Others (specify)	0	0			19.00
20.00	Total (sum of lines 1-19)	496	0			20.00
21.00	Total cost to be allocated	419	0			21.00
22.00	Unit cost multiplier	0.844758	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2012 To 04/30/2013 | Worksheet H-3 Part I | Date/Time Prepared: 9/25/2013 9:09 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	724,167		724,167	4,584	157.98	1.00
2.00	Physical Therapy	3.00	416,979	0	416,979	3,592	116.09	2.00
3.00	Occupational Therapy	4.00	47,584	0	47,584	382	124.57	3.00
4.00	Speech Pathology	5.00	19,769	0	19,769	144	137.28	4.00
5.00	Medical Social Services	6.00	161		161	1	161.00	5.00
6.00	Home Health Aide	7.00	155,554		155,554	893	174.19	6.00
7.00	Total (sum of lines 1-6)		1,364,214	0	1,364,214	9,596		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		37900	1,836	824			8.00
8.01	Skilled Nursing Care		99914	130	151			8.01
9.00	Physical Therapy		37900	1,455	676			9.00
9.01	Physical Therapy		99914	112	74			9.01
10.00	Occupational Therapy		37900	174	116			10.00
10.01	Occupational Therapy		99914	1	4			10.01
11.00	Speech Pathology		37900	74	35			11.00
11.01	Speech Pathology		99914	0	7			11.01
12.00	Medical Social Services		37900	0	1			12.00
12.01	Medical Social Services		99914	0	0			12.01
13.00	Home Health Aide		37900	374	409			13.00
13.01	Home Health Aide		99914	22	40			13.01
14.00	Total (sum of lines 8-13)			4,178	2,337			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)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	6,696	4,832	11,528	11,193	1.029929	15.00
16.00	Cost of Drugs	9.00	861	0	861	968	0.889463	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	1,966	975		310,589	154,031		1.00
2.00	Physical Therapy	1,567	750		181,913	87,068		2.00
3.00	Occupational Therapy	175	120		21,800	14,948		3.00
4.00	Speech Pathology	74	42		10,159	5,766		4.00
5.00	Medical Social Services	0	1		0	161		5.00
6.00	Home Health Aide	396	449		68,979	78,211		6.00
7.00	Total (sum of lines 1-6)	4,178	2,337		593,440	340,185		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2012 To 04/30/2013 | Worksheet H-3 Part I | Date/Time Prepared: 9/25/2013 9:09 am

Title XVIII | Home Health Agency I | PPS

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

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies							15.00
16.00	Cost of Drugs		300	0		267	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	464,620						1.00
2.00	Physical Therapy	268,981						2.00
3.00	Occupational Therapy	36,748						3.00
4.00	Speech Pathology	15,925						4.00
5.00	Medical Social Services	161						5.00
6.00	Home Health Aide	147,190						6.00
7.00	Total (sum of lines 1-6)	933,625						7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140120 | Period: From 05/01/2012 To 04/30/2013 | Worksheet H-3 Part II | Date/Time Prepared: 9/25/2013 9:09 am

HHA CCN: 147057 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.319170	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.381850	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	1.054731	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.431733	11,193	4,832	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.187400	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2012 To 04/30/2013 | Worksheet H-4 Part I-II | Date/Time Prepared: 9/25/2013 9:09 am

Title XVIII | Home Health Agency I | PPS

			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	267	0	1.00
2.00	Total charges		0	300	0	2.00
	Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)		0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)		0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)		0	300	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)		0	33	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	267	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		615,139	334,640	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		8,648	336	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		8,912	3,684	13.00
14.00	Total PPS Reimbursement - PEP Episodes		2,665	3,627	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		614	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	31	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)		635,978	342,585	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		635,978	342,585	24.00
25.00	Coinsurance billed to program patients (from your records)			0	25.00
26.00	Net cost (line 24 minus line 25)		635,978	342,585	26.00
27.00	Reimbursable bad debts (from your records)		0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0	28.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140120
HHA CCN: 147057

Period:
From 05/01/2012
To 04/30/2013

Worksheet H-4
Part I-II
Date/Time Prepared:
9/25/2013 9:09 am

Title XVIII | Home Health Agency I | PPS

		Part A Services	Part B Services	
		1.00	2.00	
29.00	Total costs - current cost reporting period (line 26 plus line 27)	635,978	342,585	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	635,978	342,585	31.00
32.00	Interim payments (see instructions)	635,978	342,468	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	117	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: 140120 HHA CCN: 147057 | Period: From 05/01/2012 To 04/30/2013 | Worksheet H-5 | Date/Time Prepared: 9/25/2013 9:09 am

Home Health Agency I | PPS

			Inpatient Part A		Part B		
			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
			1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider			635,978		342,468	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)			635,978		342,468	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		117	6.01
6.02	SETTLEMENT TO PROGRAM			0		0	6.02
7.00	Total Medicare program liability (see instructions)			635,978		342,585	7.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140120 HHA CCN: 147057	Period: From 05/01/2012 To 04/30/2013	Worksheet H-5 Date/Time Prepared: 9/25/2013 9:09 am
		Home Health Agency I	PPS

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

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140120	Period: From 05/01/2012 To 04/30/2013	Worksheet L Parts I-III Date/Time Prepared: 9/25/2013 9:09 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	791,857	1.00
2.00	Capital DRG outlier payments	32,302	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	40.16	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)	0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)	824,159	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