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: 141306

Period:
From 07/01/2011
To 06/30/2012

Worksheet S
Parts I-III
Date/Time Prepared:
11/18/2012 8:05 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/18/2012 Time: 8:05 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 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 COMMUNITY MEMORIAL HOSPITAL for the cost reporting period beginning 07/01/2011 and ending 06/30/2012 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 11/18/2012 Time: 8:05 am
s8SiZabfofPHOHVshO8BbpgJBqqX40
YHVr00oOa7WHtIen1g3yd1eDKJ2IHf
KGAA0J:vLl0BRJoj

PI: Date: 11/18/2012 Time: 8:05 am
IsCqpgwDqRV63gNrgoGEJO068uOnq0
92BS90DefU3HUcrNZTn9VbeQRgeZpt
aG82I7W4PP0FZ517

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

_____
Title

_____
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	63,226	226,467	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	15,588	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	78,814	226,467	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 11/15/2012 5:00 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 400 CALDWELL STREET	PO Box:			1.00
2.00	City: STAUNTON	State: IL	Zip Code: 62088-1499	County: MACOUPIN	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	COMMUNITY MEMORIAL HOSPITAL	141306	99914	1	08/01/2000	N	O	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	COMMUNITY MEMORIAL HOSPITAL - SWB	14Z306	99914		08/01/2000	N	O	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA						N	N	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) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2011	06/30/2012	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.	3	N	23.00

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

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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141306	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/15/2012 5:00 pm

		Beginning:	Ending:	
		1.00	2.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	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	If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 11/15/2012 5:00 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. 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. (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: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I Date/Time Prepared: 11/15/2012 5:00 pm

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

		1.00	
	Long Term Care Hospital PPS		
80.00	Are you a long term care hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. LTCHs can only exist as independent/freestanding facilities. An independent or freestanding facility may exist as an unrelated hospital within a hospital, it must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22(e.)	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.	N	86.00

		V	XIX	
		1.00	2.00	
	Title V or XIX Inpatient Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		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.	Y	Y	Y	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 11/15/2012 5:00 pm

		1.00	2.00	3.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self insurance paid in column 3.	74,593	0	0	118.01

		1.00	2.00	
118.02	Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.	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.	N		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I Date/Time Prepared: 11/15/2012 5:00 pm

		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
					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.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 11/15/2012 5:00 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		
		Description	Y/N	Date	
		0	1.00	2.00	
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	09/26/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II Date/Time Prepared: 11/15/2012 5:00 pm

		Description	Part A Y/N	Part A Date		
		0	1.00	2.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N			21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				Y	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	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.				Y	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BRIAN	ENGELKE	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY MEMORIAL HOSPITAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-635-4242	BENGELKE@STAUNTONHOSPITAL.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II Date/Time Prepared: 11/15/2012 5:00 pm

		Part B		
		Y/N	Date	
		3.00	4.00	
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	09/26/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
			3.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		CFO	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: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 11/15/2012 5:00 pm

	Cost Center Description	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours		
		1.00	2.00	3.00	4.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	21	7,686	17,086.00		1.00
2.00	HMO						2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,686	17,086.00		7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,464	0.00		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,150	17,086.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 11/15/2012 5:00 pm

	Cost Center Description	I/P Days / O/P Visits / Trips					
		Title V	Title XVIII	Title XIX	Total All Patients		
		5.00	6.00	7.00	8.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	414	23	538		1.00
2.00	HMO		0	0			2.00
3.00	HMO IPF		0	0			3.00
4.00	HMO IRF		0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	482	0	482		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	28		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	896	23	1,048		7.00
8.00	INTENSIVE CARE UNIT	0	153	0	190		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	1,049	23	1,238		14.00
15.00	CAH visits	0	0	0	0		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0		22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)						27.00
28.00	Observation Bed Days	0		0	175		28.00
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)			0	0		32.00
33.00	LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 11/15/2012 5:00 pm

	Cost Center Description	Full Time Equivalents			Discharges		
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
		9.00	10.00	11.00	12.00	13.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	167	1.00
2.00	HMO					0	2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	118.99	0.00	0	167	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00	0.00	0.00			22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00	118.99	0.00			27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 11/15/2012 5:00 pm

	Cost Center Description	Discharges			
		Title XIX	Total All Patients		
		14.00	15.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	10	227		1.00
2.00	HMO				2.00
3.00	HMO IPF				3.00
4.00	HMO IRF				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF				5.00
6.00	Hospital Adults & Peds. Swing Bed NF				6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00	INTENSIVE CARE UNIT				8.00
9.00	CORONARY CARE UNIT				9.00
10.00	BURN INTENSIVE CARE UNIT				10.00
11.00	SURGICAL INTENSIVE CARE UNIT				11.00
12.00	OTHER SPECIAL CARE (SPECIFY)				12.00
13.00	NURSERY				13.00
14.00	Total (see instructions)	10	227		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF				16.00
17.00	SUBPROVIDER - IRF				17.00
18.00	SUBPROVIDER				18.00
19.00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE				21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00	HOSPICE				24.00
25.00	CMHC - CMHC				25.00
26.00	RURAL HEALTH CLINIC				26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
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 UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-10 | Date/Time Prepared: 11/15/2012 5:00 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)	0.494272	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,384,209	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?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	3,519,382	6.00
7.00	Medicaid cost (line 1 times line 6)	1,739,532	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)	355,323	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	32,500	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	355,323	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	79,212	36,425	115,637	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	39,152	18,004	57,156	21.00
22.00	Partial payment by patients approved for charity care	1,925	833	2,758	22.00
23.00	Cost of charity care (line 21 minus line 22)	37,227	17,171	54,398	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)	1,219,692	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	190,645	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	1,029,047	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	508,629	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	563,027	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	918,350	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A | Date/Time Prepared: 11/15/2012 5:00 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		528,483	528,483	-521,125	7,358	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - BLDG 1		0	0	21,402	21,402	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - BLDG 2		0	0	90,820	90,820	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	468,554	468,554	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	0	1,243,120	1,243,120	127,490	1,370,610	4.00
5.01	00520	ALL OTHER A&G	821,469	956,396	1,777,865	-787,122	990,743	5.01
5.02	00550	DATA PROCESSING	0	0	0	236,565	236,565	5.02
5.03	00560	BILLING, COLLECTION & ADMITTING	0	0	0	378,104	378,104	5.03
7.00	00700	OPERATION OF PLANT	161,212	360,383	521,595	828	522,423	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,250	7,626	30,876	0	30,876	8.00
9.00	00900	HOUSEKEEPING	158,359	23,394	181,753	0	181,753	9.00
10.00	01000	DIETARY	133,166	96,617	229,783	-152,858	76,925	10.00
11.00	01100	CAFETERIA	0	0	0	152,858	152,858	11.00
13.00	01300	NURSING ADMINISTRATION	239,805	15,381	255,186	0	255,186	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	152,116	37,493	189,609	0	189,609	16.00
17.00	01700	SOCIAL SERVICE	56,899	0	56,899	0	56,899	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	277,383	277,383	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	643,724	34,394	678,118	0	678,118	30.00
31.00	03100	INTENSIVE CARE UNIT	243,746	70	243,816	0	243,816	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	229,107	63,569	292,676	0	292,676	50.00
51.00	05100	RECOVERY ROOM	32,606	0	32,606	0	32,606	51.00
53.00	05300	ANESTHESIOLOGY	0	280,599	280,599	-277,383	3,216	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	419,822	530,844	950,666	0	950,666	54.00
60.00	06000	LABORATORY	495,730	628,624	1,124,354	0	1,124,354	60.00
64.00	06400	INTRAVENOUS THERAPY	0	7,630	7,630	0	7,630	64.00
65.00	06500	RESPIRATORY THERAPY	159,591	150,071	309,662	-25,403	284,259	65.00
66.00	06600	PHYSICAL THERAPY	31,046	564,279	595,325	8,261	603,586	66.00
68.00	06800	SPEECH PATHOLOGY	0	4,933	4,933	0	4,933	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	90,992	196,348	287,340	25,403	312,743	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	179,670	429,089	608,759	0	608,759	73.00
76.00	03020	CARDIAC REHAB	56,559	1,367	57,926	0	57,926	76.00
76.01	03550	BEHAVIORAL HEALTH	117,793	128,410	246,203	0	246,203	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	36,795	8,004	44,799	0	44,799	90.00
91.00	09100	EMERGENCY	394,238	1,314,130	1,708,368	0	1,708,368	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	5,457	5,457	-5,457	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		12,732	12,732	-12,732	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,877,695	7,629,443	12,507,138	5,588	12,512,726	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	640,013	128,213	768,226	-5,588	762,638	192.00
194.00	07950	MEDICAL OFFICE BUILDING	0	107,480	107,480	0	107,480	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	5,517,708	7,865,136	13,382,844	0	13,382,844	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A | Date/Time Prepared: 11/15/2012 5:00 pm

		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	0	7,358		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - BLDG 1	0	21,402		1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - BLDG 2	0	90,820		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-12,732	455,822		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS	0	1,370,610		4.00
5.01	00520	ALL OTHER A&G	-203,096	787,647		5.01
5.02	00550	DATA PROCESSING	0	236,565		5.02
5.03	00560	BILLING, COLLECTION & ADMITTING	-4,000	374,104		5.03
7.00	00700	OPERATION OF PLANT	0	522,423		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	30,876		8.00
9.00	00900	HOUSEKEEPING	0	181,753		9.00
10.00	01000	DIETARY	-810	76,115		10.00
11.00	01100	CAFETERIA	-32,802	120,056		11.00
13.00	01300	NURSING ADMINISTRATION	-1,756	253,430		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,701	182,908		16.00
17.00	01700	SOCIAL SERVICE	0	56,899		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	277,383		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	678,118		30.00
31.00	03100	INTENSIVE CARE UNIT	0	243,816		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	292,676		50.00
51.00	05100	RECOVERY ROOM	0	32,606		51.00
53.00	05300	ANESTHESIOLOGY	0	3,216		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	-300	950,366		54.00
60.00	06000	LABORATORY	-51,000	1,073,354		60.00
64.00	06400	INTRAVENOUS THERAPY	0	7,630		64.00
65.00	06500	RESPIRATORY THERAPY	-20,528	263,731		65.00
66.00	06600	PHYSICAL THERAPY	0	603,586		66.00
68.00	06800	SPEECH PATHOLOGY	0	4,933		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,135	311,608		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-625	608,134		73.00
76.00	03020	CARDIAC REHAB	-5,505	52,421		76.00
76.01	03550	BEHAVIORAL HEALTH	0	246,203		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-16,965	27,834		90.00
91.00	09100	EMERGENCY	-422,542	1,285,826		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-780,497	11,732,229		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	762,638		192.00
194.00	07950	MEDICAL OFFICE BUILDING	0	107,480		194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-780,497	12,602,347		200.00

RECLASSIFICATIONS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-6 | Date/Time Prepared: 11/15/2012 5:00 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT - BLDG 1	1.01	0	19,440		1.00
2.00	CAP REL COSTS-BLDG & FIXT - BLDG 2	1.02	0	80,811		2.00
3.00	PHYSICAL THERAPY	66.00	0	8,261		3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	413,161		4.00
5.00	OPERATION OF PLANT	7.00	0	828		5.00
	TOTALS		0	522,501		
	B - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS	4.00	0	70,351		1.00
	TOTALS		0	70,351		
	C - INTEREST EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	12,732		1.00
	TOTALS		0	12,732		
	D - EQUIPMENT RENTAL					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	33,462		1.00
	TOTALS		0	33,462		
	E - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	88,586	64,272		1.00
	TOTALS		88,586	64,272		
	F - OXYGEN EXPENSE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	25,403		1.00
	TOTALS		0	25,403		
	G - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	22,546		1.00
	TOTALS		0	22,546		
	H - ADVERTISING					
1.00	ALL OTHER A&G	5.01	0	5,588		1.00
	TOTALS		0	5,588		
	I - ADMINISTRATVE EXPENSES					
1.00	EMPLOYEE BENEFITS	4.00	57,139	0		1.00
2.00	DATA PROCESSING	5.02	133,928	102,637		2.00
3.00	BILLING, COLLECTION & ADMITTING	5.03	288,114	89,990		3.00
	TOTALS		479,181	192,627		
	J - CRNA					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	277,383		1.00
	TOTALS		0	277,383		
	K - DISCONTINUED SERVICE					
1.00	ALL OTHER A&G	5.01	0	5,457		1.00
	TOTALS		0	5,457		
500.00	Grand Total: Increases		567,767	1,232,322		500.00

RECLASSIFICATIONS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-6 | Date/Time Prepared: 11/15/2012 5:00 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	522,501	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	9		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		0	522,501			
	B - EMPLOYEE BENEFITS						
1.00	ALL OTHER A&G	5.01	0	70,351	0		1.00
	TOTALS		0	70,351			
	C - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	12,732	11		1.00
	TOTALS		0	12,732			
	D - EQUIPMENT RENTAL						
1.00	ALL OTHER A&G	5.01	0	33,462	10		1.00
	TOTALS		0	33,462			
	E - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	88,586	64,272	0		1.00
	TOTALS		88,586	64,272			
	F - OXYGEN EXPENSE						
1.00	RESPIRATORY THERAPY	65.00	0	25,403	0		1.00
	TOTALS		0	25,403			
	G - PROPERTY INSURANCE						
1.00	ALL OTHER A&G	5.01	0	22,546	0		1.00
	TOTALS		0	22,546			
	H - ADVERTISING						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,588	0		1.00
	TOTALS		0	5,588			
	I - ADMINISTRATVE EXPENSES						
1.00	ALL OTHER A&G	5.01	479,181	192,627	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		479,181	192,627			
	J - CRNA						
1.00	ANESTHESIOLOGY	53.00	0	277,383	0		1.00
	TOTALS		0	277,383			
	K - DISCONTINUED SERVICE						
1.00	HOME HEALTH AGENCY	101.00	0	5,457	0		1.00
	TOTALS		0	5,457			
500.00	Grand Total: Decreases		567,767	1,232,322			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 11/15/2012 5:00 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	443,004	77,382	0	77,382	0	1.00
2.00	Land Improvements	466,822	8,562	0	8,562	0	2.00
3.00	Buildings and Fixtures	3,424,232	8,726	0	8,726	0	3.00
4.00	Building Improvements	2,387,235	35,601	0	35,601	0	4.00
5.00	Fixed Equipment	166,316	13,577	0	13,577	11,408	5.00
6.00	Movable Equipment	4,087,982	581,324	0	581,324	256,304	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	10,975,591	725,172	0	725,172	267,712	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	10,975,591	725,172	0	725,172	267,712	10.00

		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	528,483	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - BLDG 1	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - BLDG 2	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	528,483	0	0	0	0	3.00

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	652,767	0	652,767	0.061037	1,376	1.00
1.01	CAP REL COSTS-BLDG & FIXT - BLDG 1	930,645	0	930,645	0.087020	1,962	1.01
1.02	CAP REL COSTS-BLDG & FIXT - BLDG 2	4,747,766	0	4,747,766	0.443941	10,009	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	4,581,487	218,063	4,363,424	0.408002	9,199	2.00
3.00	Total (sum of lines 1-2)	10,912,665	218,063	10,694,602	1.000000	22,546	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 11/15/2012 5:00 pm

		Ending Balance	Fully Depreciated Assets		
		6.00	7.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES				
1.00	Land	520,386	0		1.00
2.00	Land Improvements	475,384	0		2.00
3.00	Buildings and Fixtures	3,432,958	0		3.00
4.00	Building Improvements	2,422,836	0		4.00
5.00	Fixed Equipment	168,485	0		5.00
6.00	Movable Equipment	4,413,002	0		6.00
7.00	HIT designated Assets	0	0		7.00
8.00	Subtotal (sum of lines 1-7)	11,433,051	0		8.00
9.00	Reconciling Items	0	0		9.00
10.00	Total (line 8 minus line 9)	11,433,051	0		10.00

	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	0	528,483		1.00
1.01	CAP REL COSTS-BLDG & FIXT - BLDG 1	0	0		1.01
1.02	CAP REL COSTS-BLDG & FIXT - BLDG 2	0	0		1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	528,483		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	1,376	5,982	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - BLDG 1	0	0	1,962	19,440	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - BLDG 2	0	0	10,009	80,811	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	9,199	413,161	33,462	2.00
3.00	Total (sum of lines 1-2)	0	0	22,546	519,394	33,462	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 11/15/2012 5:00 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,376	0	0	7,358	1.00
1.01	CAP REL COSTS-BLDG & FIXT - BLDG 1	0	1,962	0	0	21,402	1.01
1.02	CAP REL COSTS-BLDG & FIXT - BLDG 2	0	10,009	0	0	90,820	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	9,199	0	0	455,822	2.00
3.00	Total (sum of lines 1-2)	0	22,546	0	0	575,402	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 11/15/2012 5:00 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - BLDG 1 (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - BLDG 1	1.01	1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT - BLDG 2 (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - BLDG 2	1.02	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-12,732	CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)		0		0.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-28,283	ALL OTHER A&G	5.01	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-16,965	CLINIC	90.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-6,851	ALL OTHER A&G	5.01	7.00
8.00	Television and radio service (chapter 21)	A	-1,408	ALL OTHER A&G	5.01	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-494,070			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-32,802	CAFETERIA	11.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-1,135	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	16.00
17.00	Sale of drugs to other than patients	B	-625	DRUGS CHARGED TO PATIENTS	73.00	17.00
18.00	Sale of medical records and abstracts	B	-4,120	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - BLDG 1		0	CAP REL COSTS-BLDG & FIXT - BLDG 1	1.01	26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT - BLDG 2		0	CAP REL COSTS-BLDG & FIXT - BLDG 2	1.02	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	IHA LOBBYING FEES	A	-4,778	ALL OTHER A&G	5.01	33.00
33.01	TAXES	A	-23,324	ALL OTHER A&G	5.01	33.01
33.02	MEDICAID PROVIDER TAX	A	-75,123	ALL OTHER A&G	5.01	33.02
33.03	TRANSCRIPTION SERVICE	B	-2,581	MEDICAL RECORDS & LIBRARY	16.00	33.03
33.04	MISCELLANEOUS OPERATING REVENUE	B	-1,434	ALL OTHER A&G	5.01	33.04
33.05	X-RAY FILM COPYING	B	-300	RADIOLOGY - DIAGNOSTIC	54.00	33.05
33.06	INSERVICE EDUCATION	B	-1,756	NURSING ADMINISTRATION	13.00	33.06
33.07	CARDIAC REHAB	B	-5,505	CARDIAC REHAB	76.00	33.07
33.08	DIABETIC CONSULTATION	B	-810	DIETARY	10.00	33.08
33.09	PUBLIC RELATIONS SALARIES	A	-8,969	ALL OTHER A&G	5.01	33.09
33.10	PUBLIC RELATIONS OTHER	A	-7,578	ALL OTHER A&G	5.01	33.10
33.11	PUBLIC RELATIONS BENEFITS	A	-2,135	ALL OTHER A&G	5.01	33.11
33.12	PUBLIC RELATIONS OTHER	A	-4,000	BILLING, COLLECTION & ADMITTING	5.03	33.12

ADJUSTMENTS TO EXPENSES | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 11/15/2012 5:00 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
33.13	PHYSICIAN ADVERTISING EXPENSE	A	-5,588	ALL OTHER A&G	5.01	33.13
33.14	PHYSICIAN RECRUITMENT	A	-37,625	ALL OTHER A&G	5.01	33.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-780,497			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 11/15/2012 5:00 pm

	Cost Center Description	Wkst. A-7 Ref. 5.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0		1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - BLDG 1 (chapter 2)	0		1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT - BLDG 2 (chapter 2)	0		1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	11		2.00
3.00	Investment income - other (chapter 2)	0		3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0		4.00
5.00	Refunds and rebates of expenses (chapter 8)	0		5.00
6.00	Rental of provider space by suppliers (chapter 8)	0		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0		7.00
8.00	Television and radio service (chapter 21)	0		8.00
9.00	Parking lot (chapter 21)	0		9.00
10.00	Provider-based physician adjustment	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0		11.00
12.00	Related organization transactions (chapter 10)	0		12.00
13.00	Laundry and linen service	0		13.00
14.00	Cafeteria-employees and guests	0		14.00
15.00	Rental of quarters to employee and others	0		15.00
16.00	Sale of medical and surgical supplies to other than patients	0		16.00
17.00	Sale of drugs to other than patients	0		17.00
18.00	Sale of medical records and abstracts	0		18.00
19.00	Nursing school (tuition, fees, books, etc.)	0		19.00
20.00	Vending machines	0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	0		26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - BLDG 1	0		26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT - BLDG 2	0		26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	0		27.00
28.00	Non-physician Anesthetist			28.00
29.00	Physicians' assistant	0		29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0		32.00
33.00	IHA LOBBYING FEES	0		33.00
33.01	TAXES	0		33.01
33.02	MEDICAID PROVIDER TAX	0		33.02
33.03	TRANSCRIPTION SERVICE	0		33.03
33.04	MISCELLANEOUS OPERATING REVENUE	0		33.04
33.05	X-RAY FILM COPYING	0		33.05
33.06	INSERVICE EDUCATION	0		33.06
33.07	CARDIAC REHAB	0		33.07
33.08	DIABETIC CONSULTATION	0		33.08
33.09	PUBLIC RELATIONS SALARIES	0		33.09
33.10	PUBLIC RELATIONS OTHER	0		33.10
33.11	PUBLIC RELATIONS BENEFITS	0		33.11
33.12	PUBLIC RELATIONS OTHER	0		33.12
33.13	PHYSICIAN ADVERTISING EXPENSE	0		33.13
33.14	PHYSICIAN RECRUITMENT	0		33.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 11/15/2012 5:00 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		60.00	LABORATORY	51,000	51,000	1.00
2.00		65.00	RESPIRATORY THERAPY	20,528	20,528	2.00
3.00		91.00	EMERGENCY	1,285,229	422,542	3.00
4.00		76.01	BEHAVIORAL HEALTH	30,000	0	4.00
5.00		0.00		0	0	5.00
6.00		0.00		0	0	6.00
7.00		0.00		0	0	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00				1,386,757	494,070	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 11/15/2012 5:00 pm

		Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
		5.00	6.00	7.00	8.00	9.00	
1.00		0	0	0	0	0	1.00
2.00		0	0	0	0	0	2.00
3.00		862,687	0	0	0	0	3.00
4.00		30,000	0	0	0	0	4.00
5.00		0	0	0	0	0	5.00
6.00		0	0	0	0	0	6.00
7.00		0	0	0	0	0	7.00
8.00		0	0	0	0	0	8.00
9.00		0	0	0	0	0	9.00
10.00		0	0	0	0	0	10.00
200.00		892,687		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 11/15/2012 5:00 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 11/15/2012 5:00 pm

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	51,000		1.00
2.00		0	20,528		2.00
3.00		0	422,542		3.00
4.00		0	0		4.00
5.00		0	0		5.00
6.00		0	0		6.00
7.00		0	0		7.00
8.00		0	0		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		0	494,070		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/15/2012 5:00 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					255	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.85	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	2,080.00	1,257.00	4,466.00	634.00	0.00	9.00
10.00	AHSEA (see instructions)	97.97	72.57	54.43	36.29	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.29	36.29	27.22			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					203,778	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					91,220	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					243,084	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					538,082	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					23,008	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					561,090	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					561,090	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					9,254	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					9,254	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,492	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					10,746	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					9,254	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/15/2012 5:00 pm

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.57	54.43	36.29	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	561,090		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	9,254		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	570,344		63.00
64.00	Total cost of outside supplier services (from your records)	531,046		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	9,254		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,492		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	10,746		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,492		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	1,492		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/15/2012 5:00 pm

		Occupational Therapy	Cost
		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	38	1.00
2.00	Line 1 multiplied by 15 hours per week	570	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	140	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	6	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	5.85	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	252.00	9.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	92.87	68.79	51.59	34.40	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.40	34.40	25.80			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	17,335	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	464	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	17,799	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	17,799	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	68.20	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	38,874	22.00
23.00	Total salary equivalency (see instructions)	38,874	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	4,816	24.00
25.00	Assistants (line 4 times column 3, line 11)	155	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	4,971	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	854	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	5,825	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	5,825	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/15/2012 5:00 pm

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	68.79	51.59	34.40	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	38,874	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	5,825	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	44,699	63.00
64.00	Total cost of outside supplier services (from your records)	17,818	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	4,971	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	854	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	5,825	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	854	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	854	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/15/2012 5:00 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					15	1.00
2.00	Line 1 multiplied by 15 hours per week					225	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					33	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.85	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	71.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	66.10	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.05	33.05	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					4,693	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					4,693	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					4,693	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					66.10	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					14,873	22.00
23.00	Total salary equivalency (see instructions)					14,873	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					1,091	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					1,091	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					193	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					1,284	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					1,284	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/15/2012 5:00 pm

		Speech Pathology	Cost	
			1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	66.10	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		14,873	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		1,284	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		16,157	63.00
64.00	Total cost of outside supplier services (from your records)		4,933	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		1,091	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		193	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		1,284	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		193	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		193	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I Date/Time Prepared: 11/15/2012 5:00 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - BLDG 1	BLDG & FIXT - BLDG 2	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,358	7,358				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - BLDG 1	21,402	0	21,402			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - BLDG 2	90,820	0	0	90,820		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	455,822				455,822	2.00
4.00	00400	EMPLOYEE BENEFITS	1,370,610	0	0	0	0	4.00
5.01	00520	ALL OTHER A&G	787,647	734	4,503	3,439	43,390	5.01
5.02	00550	DATA PROCESSING	236,565	0	0	0	0	5.02
5.03	00560	BILLING, COLLECTION & ADMITTING	374,104	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	522,423	1,715	6,236	18,172	101,280	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,876	148	1,202	0	8,761	8.00
9.00	00900	HOUSEKEEPING	181,753	132	393	1,614	7,823	9.00
10.00	01000	DIETARY	76,115	188	0	3,623	11,134	10.00
11.00	01100	CAFETERIA	120,056	133	0	2,555	7,850	11.00
13.00	01300	NURSING ADMINISTRATION	253,430	73	0	1,413	4,342	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	182,908	138	135	2,329	8,139	16.00
17.00	01700	SOCIAL SERVICE	56,899	30	0	568	1,746	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	277,383	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	678,118	1,084	0	20,863	64,109	30.00
31.00	03100	INTENSIVE CARE UNIT	243,816	132	0	2,532	7,779	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	292,676	382	0	7,355	22,601	50.00
51.00	05100	RECOVERY ROOM	32,606	88	0	1,690	5,193	51.00
53.00	05300	ANESTHESIOLOGY	3,216	10	0	195	600	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	950,366	521	0	10,027	30,811	54.00
60.00	06000	LABORATORY	1,073,354	194	1,572	0	11,456	60.00
64.00	06400	INTRAVENOUS THERAPY	7,630	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	263,731	134	0	2,581	7,932	65.00
66.00	06600	PHYSICAL THERAPY	603,586	0	0	0	17,457	66.00
68.00	06800	SPEECH PATHOLOGY	4,933	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	311,608	168	1,366	0	9,950	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	608,134	70	0	1,349	4,146	73.00
76.00	03020	CARDIAC REHAB	52,421	184	0	3,549	10,905	76.00
76.01	03550	BEHAVIORAL HEALTH	246,203	308	2,501	0	18,220	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	27,834	125	0	2,407	7,397	90.00
91.00	09100	EMERGENCY	1,285,826	212	0	4,076	12,525	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,732,229	6,903	17,908	90,337	425,546	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	25	0	483	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	762,638	316	2,566	0	0	192.00
194.00	07950	MEDICAL OFFICE BUILDING	107,480	114	928	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	30,276	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,602,347	7,358	21,402	90,820	455,822	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I | Date/Time Prepared: 11/15/2012 5:00 pm

		Cost Center Description	EMPLOYEE BENEFITS	Subtotal	ALL OTHER A&G	Subtotal	DATA PROCESSING	
			4.00	4A	5.01	5A.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	1,370,610					4.00
5.01	00520	ALL OTHER A&G	85,915	925,628	925,628			5.01
5.02	00550	DATA PROCESSING	33,616	270,181	21,418	291,599	291,599	5.02
5.03	00560	BILLING, COLLECTION & ADMITTING	72,317	446,421	35,388	481,809	11,413	5.03
7.00	00700	OPERATION OF PLANT	40,464	690,290	54,720	745,010	17,647	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,836	46,823	3,712	50,535	1,197	8.00
9.00	00900	HOUSEKEEPING	39,748	231,463	18,348	249,811	5,917	9.00
10.00	01000	DIETARY	11,190	102,250	8,105	110,355	2,614	10.00
11.00	01100	CAFETERIA	22,235	152,829	12,115	164,944	3,907	11.00
13.00	01300	NURSING ADMINISTRATION	60,191	319,449	25,323	344,772	8,167	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	38,181	231,830	18,377	250,207	5,927	16.00
17.00	01700	SOCIAL SERVICE	14,282	73,525	5,828	79,353	1,880	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	277,383	21,988	299,371	7,091	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	161,577	925,751	73,385	999,136	23,667	30.00
31.00	03100	INTENSIVE CARE UNIT	61,180	315,439	25,005	340,444	8,064	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,506	380,520	30,164	410,684	9,728	50.00
51.00	05100	RECOVERY ROOM	8,184	47,761	3,786	51,547	1,221	51.00
53.00	05300	ANESTHESIOLOGY	0	4,021	319	4,340	103	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	105,376	1,097,101	86,968	1,184,069	28,047	54.00
60.00	06000	LABORATORY	124,429	1,211,005	95,998	1,307,003	30,959	60.00
64.00	06400	INTRAVENOUS THERAPY	0	7,630	605	8,235	195	64.00
65.00	06500	RESPIRATORY THERAPY	40,058	314,436	24,926	339,362	8,038	65.00
66.00	06600	PHYSICAL THERAPY	7,793	628,836	49,848	678,684	16,076	66.00
68.00	06800	SPEECH PATHOLOGY	0	4,933	391	5,324	126	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,839	345,931	27,422	373,353	8,844	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,097	658,796	52,223	711,019	16,842	73.00
76.00	03020	CARDIAC REHAB	14,196	81,255	6,441	87,696	2,077	76.00
76.01	03550	BEHAVIORAL HEALTH	29,566	296,798	23,527	320,325	7,588	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,236	46,999	3,726	50,725	1,202	90.00
91.00	09100	EMERGENCY	98,954	1,401,593	111,111	1,512,704	35,824	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,209,966	11,536,877	841,167	11,452,416	264,361	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	508	40	548	13	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	160,644	926,164	73,418	999,582	23,677	192.00
194.00	07950	MEDICAL OFFICE BUILDING	0	108,522	8,603	117,125	2,774	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	30,276	2,400	32,676	774	194.01
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,370,610	12,602,347	925,628	12,602,347	291,599	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I | Date/Time Prepared: 11/15/2012 5:00 pm

		Cost Center Description	BILLING, COLLECTION & ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.03	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00520	ALL OTHER A&G						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION & ADMITTING	493,222					5.03
7.00	00700	OPERATION OF PLANT	0	762,657				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,708	73,440			8.00
9.00	00900	HOUSEKEEPING	0	19,383	0	275,111		9.00
10.00	01000	DIETARY	0	27,587	0	11,525	152,081	10.00
11.00	01100	CAFETERIA	0	19,450	0	8,126	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,759	0	4,495	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,167	0	8,425	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,325	0	1,807	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,736	158,846	63,565	66,360	131,631	30.00
31.00	03100	INTENSIVE CARE UNIT	5,881	19,275	9,875	8,052	20,450	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,088	55,999	0	23,395	0	50.00
51.00	05100	RECOVERY ROOM	3,047	12,868	0	5,376	0	51.00
53.00	05300	ANESTHESIOLOGY	10,799	1,487	0	621	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	128,412	76,341	0	31,893	0	54.00
60.00	06000	LABORATORY	143,315	28,385	0	11,858	0	60.00
64.00	06400	INTRAVENOUS THERAPY	3,425	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	29,731	19,653	0	8,210	0	65.00
66.00	06600	PHYSICAL THERAPY	41,892	43,253	0	18,070	0	66.00
68.00	06800	SPEECH PATHOLOGY	136	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,277	24,654	0	10,300	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,167	10,273	0	4,292	0	73.00
76.00	03020	CARDIAC REHAB	2,747	27,020	0	11,288	0	76.00
76.01	03550	BEHAVIORAL HEALTH	10,997	45,145	0	18,860	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	658	18,328	0	7,657	0	90.00
91.00	09100	EMERGENCY	28,498	31,034	0	12,965	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	481,806	695,940	73,440	273,575	152,081	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,676	0	1,536	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,416	46,321	0	0	0	192.00
194.00	07950	MEDICAL OFFICE BUILDING	0	16,720	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
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)	493,222	762,657	73,440	275,111	152,081	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I | Date/Time Prepared: 11/15/2012 5:00 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00520	ALL OTHER A&G						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION & ADMITTING						5.03
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	196,427					11.00
13.00	01300	NURSING ADMINISTRATION	13,157	381,350				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,346	0	293,072			16.00
17.00	01700	SOCIAL SERVICE	3,122	0	0	90,487		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	306,462	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,317	155,347	9,944	78,320	0	30.00
31.00	03100	INTENSIVE CARE UNIT	13,373	58,823	3,494	12,167	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,570	55,290	10,153	0	0	50.00
51.00	05100	RECOVERY ROOM	1,789	7,869	1,810	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	6,417	0	306,462	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	23,033	0	76,302	0	0	54.00
60.00	06000	LABORATORY	27,198	0	85,160	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	2,035	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	8,756	0	17,666	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,703	0	24,892	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	81	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,992	0	8,483	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,857	0	14,360	0	0	73.00
76.00	03020	CARDIAC REHAB	3,103	0	1,633	0	0	76.00
76.01	03550	BEHAVIORAL HEALTH	6,463	0	6,535	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,019	8,880	391	0	0	90.00
91.00	09100	EMERGENCY	21,629	95,141	16,933	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	196,427	381,350	286,289	90,487	306,462	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	6,783	0	0	192.00
194.00	07950	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	196,427	381,350	293,072	90,487	306,462	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I | Date/Time Prepared: 11/15/2012 5:00 pm

		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
1.01	00101	CAP REL COSTS-BLDG & FIXT - BLDG 1					1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - BLDG 2					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00520	ALL OTHER A&G					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	BILLING, COLLECTION & ADMITTING					5.03
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
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,738,869	0	1,738,869		30.00
31.00	03100	INTENSIVE CARE UNIT	499,898	0	499,898		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	594,907	0	594,907		50.00
51.00	05100	RECOVERY ROOM	85,527	0	85,527		51.00
53.00	05300	ANESTHESIOLOGY	330,229	0	330,229		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,548,097	0	1,548,097		54.00
60.00	06000	LABORATORY	1,633,878	0	1,633,878		60.00
64.00	06400	INTRAVENOUS THERAPY	13,890	0	13,890		64.00
65.00	06500	RESPIRATORY THERAPY	431,416	0	431,416		65.00
66.00	06600	PHYSICAL THERAPY	824,570	0	824,570		66.00
68.00	06800	SPEECH PATHOLOGY	5,667	0	5,667		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	444,903	0	444,903		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	790,810	0	790,810		73.00
76.00	03020	CARDIAC REHAB	135,564	0	135,564		76.00
76.01	03550	BEHAVIORAL HEALTH	415,913	0	415,913		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	89,860	0	89,860		90.00
91.00	09100	EMERGENCY	1,754,728	0	1,754,728		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,338,726	0	11,338,726		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	5,773	0	5,773		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,087,779	0	1,087,779		192.00
194.00	07950	MEDICAL OFFICE BUILDING	136,619	0	136,619		194.00
194.01	07951	MEDICAL OFFICE BUILDING	33,450	0	33,450		194.01
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)	12,602,347	0	12,602,347		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II | Date/Time Prepared: 11/15/2012 5:00 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	BLDG & FIXT - BLDG 1	BLDG & FIXT - BLDG 2	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.01	00520	ALL OTHER A&G	0	734	4,503	3,439	43,390	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	0	5.02
5.03	00560	BILLING, COLLECTION & ADMITTING	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	0	1,715	6,236	18,172	101,280	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	148	1,202	0	8,761	8.00
9.00	00900	HOUSEKEEPING	0	132	393	1,614	7,823	9.00
10.00	01000	DIETARY	0	188	0	3,623	11,134	10.00
11.00	01100	CAFETERIA	0	133	0	2,555	7,850	11.00
13.00	01300	NURSING ADMINISTRATION	0	73	0	1,413	4,342	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	138	135	2,329	8,139	16.00
17.00	01700	SOCIAL SERVICE	0	30	0	568	1,746	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,084	0	20,863	64,109	30.00
31.00	03100	INTENSIVE CARE UNIT	0	132	0	2,532	7,779	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	382	0	7,355	22,601	50.00
51.00	05100	RECOVERY ROOM	0	88	0	1,690	5,193	51.00
53.00	05300	ANESTHESIOLOGY	0	10	0	195	600	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	521	0	10,027	30,811	54.00
60.00	06000	LABORATORY	0	194	1,572	0	11,456	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	134	0	2,581	7,932	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	17,457	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	168	1,366	0	9,950	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	70	0	1,349	4,146	73.00
76.00	03020	CARDIAC REHAB	0	184	0	3,549	10,905	76.00
76.01	03550	BEHAVIORAL HEALTH	0	308	2,501	0	18,220	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	125	0	2,407	7,397	90.00
91.00	09100	EMERGENCY	0	212	0	4,076	12,525	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	6,903	17,908	90,337	425,546	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	25	0	483	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	316	2,566	0	0	192.00
194.00	07950	MEDICAL OFFICE BUILDING	0	114	928	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	30,276	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	7,358	21,402	90,820	455,822	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II Date/Time Prepared: 11/15/2012 5:00 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS	ALL OTHER A&G	DATA PROCESSING	BILLING, COLLECTION & ADMITTING	
			2A	4.00	5.01	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	0				4.00
5.01	00520	ALL OTHER A&G	52,066	0	52,066			5.01
5.02	00550	DATA PROCESSING	0	0	1,205	1,205		5.02
5.03	00560	BILLING, COLLECTION & ADMITTING	0	0	1,991	47	2,038	5.03
7.00	00700	OPERATION OF PLANT	127,403	0	3,078	73	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,111	0	209	5	0	8.00
9.00	00900	HOUSEKEEPING	9,962	0	1,032	24	0	9.00
10.00	01000	DIETARY	14,945	0	456	11	0	10.00
11.00	01100	CAFETERIA	10,538	0	681	16	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,828	0	1,424	34	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,741	0	1,034	25	0	16.00
17.00	01700	SOCIAL SERVICE	2,344	0	328	8	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	1,237	29	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	86,056	0	4,128	98	69	30.00
31.00	03100	INTENSIVE CARE UNIT	10,443	0	1,407	33	24	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,338	0	1,697	40	71	50.00
51.00	05100	RECOVERY ROOM	6,971	0	213	5	13	51.00
53.00	05300	ANESTHESIOLOGY	805	0	18	0	45	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	41,359	0	4,892	116	531	54.00
60.00	06000	LABORATORY	13,222	0	5,400	128	590	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	34	1	14	64.00
65.00	06500	RESPIRATORY THERAPY	10,647	0	1,402	33	123	65.00
66.00	06600	PHYSICAL THERAPY	17,457	0	2,804	67	173	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	22	1	1	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,484	0	1,543	37	59	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,565	0	2,938	70	100	73.00
76.00	03020	CARDIAC REHAB	14,638	0	362	9	11	76.00
76.01	03550	BEHAVIORAL HEALTH	21,029	0	1,323	31	46	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,929	0	210	5	3	90.00
91.00	09100	EMERGENCY	16,813	0	6,247	147	118	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	540,694	0	47,315	1,093	1,991	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	508	0	2	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,882	0	4,130	98	47	192.00
194.00	07950	MEDICAL OFFICE BUILDING	1,042	0	484	11	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	30,276	0	135	3	0	194.01
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	575,402	0	52,066	1,205	2,038	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II | Date/Time Prepared: 11/15/2012 5:00 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00520	ALL OTHER A&G						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT	130,554					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,716	14,041				8.00
9.00	00900	HOUSEKEEPING	3,318	0	14,336			9.00
10.00	01000	DIETARY	4,722	0	601	20,735		10.00
11.00	01100	CAFETERIA	3,330	0	423	0	14,988	11.00
13.00	01300	NURSING ADMINISTRATION	1,842	0	234	0	1,004	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,452	0	439	0	637	16.00
17.00	01700	SOCIAL SERVICE	740	0	94	0	238	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,195	12,153	3,457	17,947	2,697	30.00
31.00	03100	INTENSIVE CARE UNIT	3,299	1,888	420	2,788	1,020	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,586	0	1,219	0	959	50.00
51.00	05100	RECOVERY ROOM	2,203	0	280	0	136	51.00
53.00	05300	ANESTHESIOLOGY	255	0	32	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	13,068	0	1,662	0	1,757	54.00
60.00	06000	LABORATORY	4,859	0	618	0	2,075	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,364	0	428	0	668	65.00
66.00	06600	PHYSICAL THERAPY	7,404	0	942	0	130	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,220	0	537	0	381	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,758	0	224	0	752	73.00
76.00	03020	CARDIAC REHAB	4,625	0	588	0	237	76.00
76.01	03550	BEHAVIORAL HEALTH	7,728	0	983	0	493	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,138	0	399	0	154	90.00
91.00	09100	EMERGENCY	5,312	0	676	0	1,650	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	119,134	14,041	14,256	20,735	14,988	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	629	0	80	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,929	0	0	0	0	192.00
194.00	07950	MEDICAL OFFICE BUILDING	2,862	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
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)	130,554	14,041	14,336	20,735	14,988	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II | Date/Time Prepared: 11/15/2012 5:00 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			13.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00520	ALL OTHER A&G						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION & ADMITTING						5.03
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	10,366					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,328				16.00
17.00	01700	SOCIAL SERVICE	0	0	3,752			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	1,266		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,223	554	3,247		161,824	30.00
31.00	03100	INTENSIVE CARE UNIT	1,599	195	505		23,621	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,503	566	0		45,979	50.00
51.00	05100	RECOVERY ROOM	214	101	0		10,136	51.00
53.00	05300	ANESTHESIOLOGY	0	357	0		1,512	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	4,251	0		67,636	54.00
60.00	06000	LABORATORY	0	4,744	0		31,636	60.00
64.00	06400	INTRAVENOUS THERAPY	0	113	0		162	64.00
65.00	06500	RESPIRATORY THERAPY	0	984	0		17,649	65.00
66.00	06600	PHYSICAL THERAPY	0	1,387	0		30,364	66.00
68.00	06800	SPEECH PATHOLOGY	0	5	0		29	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	473	0		18,734	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	800	0		12,207	73.00
76.00	03020	CARDIAC REHAB	0	91	0		20,561	76.00
76.01	03550	BEHAVIORAL HEALTH	0	364	0		31,997	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	241	22	0		14,101	90.00
91.00	09100	EMERGENCY	2,586	943	0		34,492	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,366	15,950	3,752	0	522,640	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		1,219	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	378	0		15,464	192.00
194.00	07950	MEDICAL OFFICE BUILDING	0	0	0		4,399	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0		30,414	194.01
200.00		Cross Foot Adjustments				1,266	1,266	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	10,366	16,328	3,752	1,266	575,402	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II | Date/Time Prepared: 11/15/2012 5:00 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - BLDG 1				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - BLDG 2				1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.01	00520	ALL OTHER A&G				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00560	BILLING, COLLECTION & ADMITTING				5.03
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
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	161,824		30.00
31.00	03100	INTENSIVE CARE UNIT	0	23,621		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	45,979		50.00
51.00	05100	RECOVERY ROOM	0	10,136		51.00
53.00	05300	ANESTHESIOLOGY	0	1,512		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	67,636		54.00
60.00	06000	LABORATORY	0	31,636		60.00
64.00	06400	INTRAVENOUS THERAPY	0	162		64.00
65.00	06500	RESPIRATORY THERAPY	0	17,649		65.00
66.00	06600	PHYSICAL THERAPY	0	30,364		66.00
68.00	06800	SPEECH PATHOLOGY	0	29		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18,734		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,207		73.00
76.00	03020	CARDIAC REHAB	0	20,561		76.00
76.01	03550	BEHAVIORAL HEALTH	0	31,997		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	14,101		90.00
91.00	09100	EMERGENCY	0	34,492		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	522,640		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,219		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,464		192.00
194.00	07950	MEDICAL OFFICE BUILDING	0	4,399		194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	30,414		194.01
200.00		Cross Foot Adjustments	0	1,266		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	575,402		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 11/15/2012 5:00 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - BLDG 1 (SQUARE FEET)	BLDG & FIXT - BLDG 2 (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	
			1.00	1.01	1.02	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	79,744					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - BLDG 1	0	28,586				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - BLDG 2	0	0	51,158			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				83,558		2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0	0	5,460,569	4.00
5.01	00520	ALL OTHER A&G	7,951	6,014	1,937	7,954	342,288	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	133,928	5.02
5.03	00560	BILLING, COLLECTION & ADMITTING	0	0	0	0	288,114	5.03
7.00	00700	OPERATION OF PLANT	18,566	8,330	10,236	18,566	161,212	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,606	1,606	0	1,606	23,250	8.00
9.00	00900	HOUSEKEEPING	1,434	525	909	1,434	158,359	9.00
10.00	01000	DIETARY	2,041	0	2,041	2,041	44,580	10.00
11.00	01100	CAFETERIA	1,439	0	1,439	1,439	88,586	11.00
13.00	01300	NURSING ADMINISTRATION	796	0	796	796	239,805	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,492	180	1,312	1,492	152,116	16.00
17.00	01700	SOCIAL SERVICE	320	0	320	320	56,899	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,752	0	11,752	11,752	643,724	30.00
31.00	03100	INTENSIVE CARE UNIT	1,426	0	1,426	1,426	243,746	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,143	0	4,143	4,143	229,107	50.00
51.00	05100	RECOVERY ROOM	952	0	952	952	32,606	51.00
53.00	05300	ANESTHESIOLOGY	110	0	110	110	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	5,648	0	5,648	5,648	419,822	54.00
60.00	06000	LABORATORY	2,100	2,100	0	2,100	495,730	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,454	0	1,454	1,454	159,591	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,200	31,046	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,824	1,824	0	1,824	90,992	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	760	0	760	760	179,670	73.00
76.00	03020	CARDIAC REHAB	1,999	0	1,999	1,999	56,559	76.00
76.01	03550	BEHAVIORAL HEALTH	3,340	3,340	0	3,340	117,793	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,356	0	1,356	1,356	36,795	90.00
91.00	09100	EMERGENCY	2,296	0	2,296	2,296	394,238	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	74,805	23,919	50,886	78,008	4,820,556	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	272	0	272	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,427	3,427	0	0	640,013	192.00
194.00	07950	MEDICAL OFFICE BUILDING	1,240	1,240	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	5,550	0	194.01
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)	7,358	21,402	90,820	455,822	1,370,610	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.092270	0.748688	1.775284	5.455157	0.251001	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 11/15/2012 5:00 pm

		Cost Center Description	Reconciliation	ALL OTHER A&G (ACCUM. COST)	Reconciliation	DATA PROCESSING (ACCUM. COST)	BILLING, COLLECTION & ADMITTING (GROSS CHARGES)	
			5A.01	5.01	5A.02	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00520	ALL OTHER A&G	-925,628	11,676,719				5.01
5.02	00550	DATA PROCESSING	0	270,181	-291,599	12,310,748		5.02
5.03	00560	BILLING, COLLECTION & ADMITTING	0	446,421	0	481,809	24,010,195	5.03
7.00	00700	OPERATION OF PLANT	0	690,290	0	745,010	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	46,823	0	50,535	0	8.00
9.00	00900	HOUSEKEEPING	0	231,463	0	249,811	0	9.00
10.00	01000	DIETARY	0	102,250	0	110,355	0	10.00
11.00	01100	CAFETERIA	0	152,829	0	164,944	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	319,449	0	344,772	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	231,830	0	250,207	0	16.00
17.00	01700	SOCIAL SERVICE	0	73,525	0	79,353	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	277,383	0	299,371	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	925,751	0	999,136	814,719	30.00
31.00	03100	INTENSIVE CARE UNIT	0	315,439	0	340,444	286,291	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	380,520	0	410,684	831,841	50.00
51.00	05100	RECOVERY ROOM	0	47,761	0	51,547	148,311	51.00
53.00	05300	ANESTHESIOLOGY	0	4,021	0	4,340	525,708	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	1,097,101	0	1,184,069	6,251,211	54.00
60.00	06000	LABORATORY	0	1,211,005	0	1,307,003	6,976,442	60.00
64.00	06400	INTRAVENOUS THERAPY	0	7,630	0	8,235	166,739	64.00
65.00	06500	RESPIRATORY THERAPY	0	314,436	0	339,362	1,447,331	65.00
66.00	06600	PHYSICAL THERAPY	0	628,836	0	678,684	2,039,320	66.00
68.00	06800	SPEECH PATHOLOGY	0	4,933	0	5,324	6,642	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	345,931	0	373,353	695,010	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	658,796	0	711,019	1,176,456	73.00
76.00	03020	CARDIAC REHAB	0	81,255	0	87,696	133,746	76.00
76.01	03550	BEHAVIORAL HEALTH	0	296,798	0	320,325	535,360	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	46,999	0	50,725	32,038	90.00
91.00	09100	EMERGENCY	0	1,401,593	0	1,512,704	1,387,291	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-925,628	10,611,249	-291,599	11,160,817	23,454,456	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	508	0	548	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	926,164	0	999,582	555,739	192.00
194.00	07950	MEDICAL OFFICE BUILDING	0	108,522	0	117,125	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	30,276	0	32,676	0	194.01
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)		925,628		291,599	493,222	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.079271		0.023687	0.020542	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		52,066		1,205	2,038	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.004459		0.000098	0.000085	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 11/15/2012 5:00 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00520	ALL OTHER A&G						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT	56,424					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,606	1,413				8.00
9.00	00900	HOUSEKEEPING	1,434	0	48,720			9.00
10.00	01000	DIETARY	2,041	0	2,041	1,413		10.00
11.00	01100	CAFETERIA	1,439	0	1,439	0	3,580,239	11.00
13.00	01300	NURSING ADMINISTRATION	796	0	796	0	239,805	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,492	0	1,492	0	152,116	16.00
17.00	01700	SOCIAL SERVICE	320	0	320	0	56,899	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,752	1,223	11,752	1,223	643,724	30.00
31.00	03100	INTENSIVE CARE UNIT	1,426	190	1,426	190	243,746	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,143	0	4,143	0	229,107	50.00
51.00	05100	RECOVERY ROOM	952	0	952	0	32,606	51.00
53.00	05300	ANESTHESIOLOGY	110	0	110	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	5,648	0	5,648	0	419,822	54.00
60.00	06000	LABORATORY	2,100	0	2,100	0	495,730	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,454	0	1,454	0	159,591	65.00
66.00	06600	PHYSICAL THERAPY	3,200	0	3,200	0	31,046	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,824	0	1,824	0	90,992	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	760	0	760	0	179,670	73.00
76.00	03020	CARDIAC REHAB	1,999	0	1,999	0	56,559	76.00
76.01	03550	BEHAVIORAL HEALTH	3,340	0	3,340	0	117,793	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,356	0	1,356	0	36,795	90.00
91.00	09100	EMERGENCY	2,296	0	2,296	0	394,238	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	51,488	1,413	48,448	1,413	3,580,239	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	272	0	272	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,427	0	0	0	0	192.00
194.00	07950	MEDICAL OFFICE BUILDING	1,237	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
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)	762,657	73,440	275,111	152,081	196,427	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.516536	51.974522	5.646778	107.629866	0.054864	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	130,554	14,041	14,336	20,735	14,988	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.313803	9.937013	0.294253	14.674452	0.004186	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 11/15/2012 5:00 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			13.00	16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00520	ALL OTHER A&G						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION & ADMITTING						5.03
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	1,580,216					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,010,195				16.00
17.00	01700	SOCIAL SERVICE	0	0	1,413			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	643,724	814,719	1,223			30.00
31.00	03100	INTENSIVE CARE UNIT	243,746	286,291	190			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	229,107	831,841	0	0		50.00
51.00	05100	RECOVERY ROOM	32,606	148,311	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	525,708	0	100		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	6,251,211	0	0		54.00
60.00	06000	LABORATORY	0	6,976,442	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	166,739	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,447,331	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,039,320	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	6,642	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	695,010	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,176,456	0	0		73.00
76.00	03020	CARDIAC REHAB	0	133,746	0	0		76.00
76.01	03550	BEHAVIORAL HEALTH	0	535,360	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	36,795	32,038	0	0		90.00
91.00	09100	EMERGENCY	394,238	1,387,291	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,580,216	23,454,456	1,413	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	555,739	0	0		192.00
194.00	07950	MEDICAL OFFICE BUILDING	0	0	0	0		194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0		194.01
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)	381,350	293,072	90,487	306,462		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.241328	0.012206	64.038924	3,064.620000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,366	16,328	3,752	1,266		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006560	0.000680	2.655343	12.660000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/15/2012 5:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,738,869		1,738,869	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	499,898		499,898	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	594,907		594,907	0	0	50.00
51.00	05100	RECOVERY ROOM	85,527		85,527	0	0	51.00
53.00	05300	ANESTHESIOLOGY	330,229		330,229	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,548,097		1,548,097	0	0	54.00
60.00	06000	LABORATORY	1,633,878		1,633,878	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	13,890		13,890	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	431,416	0	431,416	0	0	65.00
66.00	06600	PHYSICAL THERAPY	824,570	0	824,570	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	5,667	0	5,667	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	444,903		444,903	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	790,810		790,810	0	0	73.00
76.00	03020	CARDIAC REHAB	135,564		135,564	0	0	76.00
76.01	03550	BEHAVIORAL HEALTH	415,913		415,913	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	89,860		89,860	0	0	90.00
91.00	09100	EMERGENCY	1,754,728		1,754,728	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	254,165		254,165		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,592,891	0	11,592,891	0	0	200.00
201.00		Less Observation Beds	254,165		254,165		0	201.00
202.00		Total (see instructions)	11,338,726	0	11,338,726	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/15/2012 5:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	558,824		558,824			30.00
31.00	03100	INTENSIVE CARE UNIT	286,291		286,291			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	62,243	769,598	831,841	0.715169	0.000000	50.00
51.00	05100	RECOVERY ROOM	8,535	139,776	148,311	0.576673	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	41,820	483,888	525,708	0.628160	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	194,949	6,056,262	6,251,211	0.247648	0.000000	54.00
60.00	06000	LABORATORY	483,089	6,493,353	6,976,442	0.234199	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	74,117	92,622	166,739	0.083304	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	342,611	1,104,720	1,447,331	0.298077	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	158,933	1,880,387	2,039,320	0.404336	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	1,204	5,438	6,642	0.853207	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	185,135	509,875	695,010	0.640139	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	287,876	888,580	1,176,456	0.672197	0.000000	73.00
76.00	03020	CARDIAC REHAB	11,026	122,720	133,746	1.013593	0.000000	76.00
76.01	03550	BEHAVIORAL HEALTH	0	535,360	535,360	0.776885	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10	32,028	32,038	2.804794	0.000000	90.00
91.00	09100	EMERGENCY	6,564	1,380,727	1,387,291	1.264859	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	255,895	255,895	0.993239	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	2,703,227	20,751,229	23,454,456			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,703,227	20,751,229	23,454,456			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/15/2012 5:00 pm

Title XVIII | Hospital | Cost

		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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	CARDIAC REHAB	0.000000		76.00
76.01	03550	BEHAVIORAL HEALTH	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/15/2012 5:00 pm

Title XIX | Hospital

		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	1,738,869		1,738,869	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	499,898		499,898	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	594,907		594,907	0	0	50.00
51.00	05100	RECOVERY ROOM	85,527		85,527	0	0	51.00
53.00	05300	ANESTHESIOLOGY	330,229		330,229	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,548,097		1,548,097	0	0	54.00
60.00	06000	LABORATORY	1,633,878		1,633,878	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	13,890		13,890	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	431,416	0	431,416	0	0	65.00
66.00	06600	PHYSICAL THERAPY	824,570	0	824,570	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	5,667	0	5,667	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	444,903		444,903	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	790,810		790,810	0	0	73.00
76.00	03020	CARDIAC REHAB	135,564		135,564	0	0	76.00
76.01	03550	BEHAVIORAL HEALTH	415,913		415,913	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	89,860		89,860	0	0	90.00
91.00	09100	EMERGENCY	1,754,728		1,754,728	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	254,165		254,165		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,592,891	0	11,592,891	0	0	200.00
201.00		Less Observation Beds	254,165		254,165		0	201.00
202.00		Total (see instructions)	11,338,726	0	11,338,726	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/15/2012 5:00 pm

Title XIX | Hospital

		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	558,824		558,824			30.00
31.00	03100	INTENSIVE CARE UNIT	286,291		286,291			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	62,243	769,598	831,841	0.715169	0.000000	50.00
51.00	05100	RECOVERY ROOM	8,535	139,776	148,311	0.576673	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	41,820	483,888	525,708	0.628160	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	194,949	6,056,262	6,251,211	0.247648	0.000000	54.00
60.00	06000	LABORATORY	483,089	6,493,353	6,976,442	0.234199	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	74,117	92,622	166,739	0.083304	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	342,611	1,104,720	1,447,331	0.298077	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	158,933	1,880,387	2,039,320	0.404336	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	1,204	5,438	6,642	0.853207	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	185,135	509,875	695,010	0.640139	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	287,876	888,580	1,176,456	0.672197	0.000000	73.00
76.00	03020	CARDIAC REHAB	11,026	122,720	133,746	1.013593	0.000000	76.00
76.01	03550	BEHAVIORAL HEALTH	0	535,360	535,360	0.776885	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10	32,028	32,038	2.804794	0.000000	90.00
91.00	09100	EMERGENCY	6,564	1,380,727	1,387,291	1.264859	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	255,895	255,895	0.993239	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	2,703,227	20,751,229	23,454,456			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,703,227	20,751,229	23,454,456			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/15/2012 5:00 pm

Title XIX | Hospital

		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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	CARDIAC REHAB	0.000000		76.00
76.01	03550	BEHAVIORAL HEALTH	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part II Date/Time Prepared: 11/15/2012 5:00 pm

Title XIX | Hospital

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	594,907	45,979	548,928	0	0	50.00
51.00	05100	RECOVERY ROOM	85,527	10,136	75,391	0	0	51.00
53.00	05300	ANESTHESIOLOGY	330,229	1,512	328,717	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,548,097	67,636	1,480,461	0	0	54.00
60.00	06000	LABORATORY	1,633,878	31,636	1,602,242	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	13,890	162	13,728	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	431,416	17,649	413,767	0	0	65.00
66.00	06600	PHYSICAL THERAPY	824,570	30,364	794,206	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	5,667	29	5,638	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	444,903	18,734	426,169	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	790,810	12,207	778,603	0	0	73.00
76.00	03020	CARDIAC REHAB	135,564	20,561	115,003	0	0	76.00
76.01	03550	BEHAVIORAL HEALTH	415,913	31,997	383,916	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	89,860	14,101	75,759	0	0	90.00
91.00	09100	EMERGENCY	1,754,728	34,492	1,720,236	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	254,165	0	254,165	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	9,354,124	337,195	9,016,929	0	0	200.00
201.00		Less Observation Beds	254,165	0	254,165	0	0	201.00
202.00		Total (line 200 minus line 201)	9,099,959	337,195	8,762,764	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part II | Date/Time Prepared: 11/15/2012 5:00 pm

Title XIX | Hospital

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	594,907	831,841	0.715169		50.00
51.00	05100	RECOVERY ROOM	85,527	148,311	0.576673		51.00
53.00	05300	ANESTHESIOLOGY	330,229	525,708	0.628160		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,548,097	6,251,211	0.247648		54.00
60.00	06000	LABORATORY	1,633,878	6,976,442	0.234199		60.00
64.00	06400	INTRAVENOUS THERAPY	13,890	166,739	0.083304		64.00
65.00	06500	RESPIRATORY THERAPY	431,416	1,447,331	0.298077		65.00
66.00	06600	PHYSICAL THERAPY	824,570	2,039,320	0.404336		66.00
68.00	06800	SPEECH PATHOLOGY	5,667	6,642	0.853207		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	444,903	695,010	0.640139		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	790,810	1,176,456	0.672197		73.00
76.00	03020	CARDIAC REHAB	135,564	133,746	1.013593		76.00
76.01	03550	BEHAVIORAL HEALTH	415,913	535,360	0.776885		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	89,860	32,038	2.804794		90.00
91.00	09100	EMERGENCY	1,754,728	1,387,291	1.264859		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	254,165	255,895	0.993239		92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	9,354,124	22,609,341			200.00
201.00		Less Observation Beds	254,165	0			201.00
202.00		Total (line 200 minus line 201)	9,099,959	22,609,341			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part II Date/Time Prepared: 11/15/2012 5:00 pm

Title XVIII | Hospital | Cost

		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	45,979	831,841	0.055274	30,684	1,696	50.00
51.00	05100	RECOVERY ROOM	10,136	148,311	0.068343	4,913	336	51.00
53.00	05300	ANESTHESIOLOGY	1,512	525,708	0.002876	21,318	61	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	67,636	6,251,211	0.010820	113,461	1,228	54.00
60.00	06000	LABORATORY	31,636	6,976,442	0.004535	297,345	1,348	60.00
64.00	06400	INTRAVENOUS THERAPY	162	166,739	0.000972	45,194	44	64.00
65.00	06500	RESPIRATORY THERAPY	17,649	1,447,331	0.012194	204,625	2,495	65.00
66.00	06600	PHYSICAL THERAPY	30,364	2,039,320	0.014889	18,452	275	66.00
68.00	06800	SPEECH PATHOLOGY	29	6,642	0.004366	980	4	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,734	695,010	0.026955	106,603	2,873	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,207	1,176,456	0.010376	167,179	1,735	73.00
76.00	03020	CARDIAC REHAB	20,561	133,746	0.153732	4,726	727	76.00
76.01	03550	BEHAVIORAL HEALTH	31,997	535,360	0.059767	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	14,101	32,038	0.440134	0	0	90.00
91.00	09100	EMERGENCY	34,492	1,387,291	0.024863	399	10	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	255,895	0.000000	0	0	92.00
200.00		Total (lines 50-199)	337,195	22,609,341		1,015,879	12,832	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 11/15/2012 5:00 pm

Title XVIII | Hospital | Cost

		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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	306,462	0	0	0	306,462	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03550	BEHAVIORAL HEALTH	0	0	0	0	0	76.01
		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)	306,462	0	0	0	306,462	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV Date/Time Prepared: 11/15/2012 5:00 pm

Title XVIII | Hospital | Cost

		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	831,841	0.000000	0.000000	30,684	50.00
51.00	05100	RECOVERY ROOM	0	148,311	0.000000	0.000000	4,913	51.00
53.00	05300	ANESTHESIOLOGY	0	525,708	0.582951	0.000000	21,318	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	6,251,211	0.000000	0.000000	113,461	54.00
60.00	06000	LABORATORY	0	6,976,442	0.000000	0.000000	297,345	60.00
64.00	06400	INTRAVENOUS THERAPY	0	166,739	0.000000	0.000000	45,194	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,447,331	0.000000	0.000000	204,625	65.00
66.00	06600	PHYSICAL THERAPY	0	2,039,320	0.000000	0.000000	18,452	66.00
68.00	06800	SPEECH PATHOLOGY	0	6,642	0.000000	0.000000	980	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	695,010	0.000000	0.000000	106,603	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,176,456	0.000000	0.000000	167,179	73.00
76.00	03020	CARDIAC REHAB	0	133,746	0.000000	0.000000	4,726	76.00
76.01	03550	BEHAVIORAL HEALTH	0	535,360	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	32,038	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	1,387,291	0.000000	0.000000	399	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	255,895	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	22,609,341			1,015,879	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 11/15/2012 5:00 pm

Title XVIII | Hospital | Cost

		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
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	12,427	0	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	CARDIAC REHAB	0	0	0		76.00
76.01	03550	BEHAVIORAL HEALTH	0	0	0		76.01
		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)	12,427	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V Date/Time Prepared: 11/15/2012 5:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
			1.00	2.00	3.00	4.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.715169	0	407,625	0		50.00
51.00	05100	RECOVERY ROOM	0.576673	0	70,870	0		51.00
53.00	05300	ANESTHESIOLOGY	0.628160	0	270,912	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.247648	0	2,504,480	0		54.00
60.00	06000	LABORATORY	0.234199	0	3,430,915	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0.083304	0	49,102	0		64.00
65.00	06500	RESPIRATORY THERAPY	0.298077	0	578,857	0		65.00
66.00	06600	PHYSICAL THERAPY	0.404336	0	707,702	0		66.00
68.00	06800	SPEECH PATHOLOGY	0.853207	0	3,482	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.640139	0	285,589	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.672197	0	622,295	0		73.00
76.00	03020	CARDIAC REHAB	1.013593	0	104,292	0		76.00
76.01	03550	BEHAVIORAL HEALTH	0.776885	0	530,148	0		76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.804794	0	14,460	0		90.00
91.00	09100	EMERGENCY	1.264859	0	486,605	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.993239	0	192,233	0		92.00
200.00		Subtotal (see instructions)		0	10,259,567	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	10,259,567	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V Date/Time Prepared: 11/15/2012 5:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs PPS Services (see instructions)	Costs Cost Services Subject To Ded. & Coins. (see instructions)	Costs Cost Services Not Subject To Ded. & Coins. (see instructions)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	291,521	0		50.00
51.00	05100	RECOVERY ROOM	0	40,869	0		51.00
53.00	05300	ANESTHESIOLOGY	0	170,176	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	620,229	0		54.00
60.00	06000	LABORATORY	0	803,517	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	4,090	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	172,544	0		65.00
66.00	06600	PHYSICAL THERAPY	0	286,149	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	2,971	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	182,817	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	418,305	0		73.00
76.00	03020	CARDIAC REHAB	0	105,710	0		76.00
76.01	03550	BEHAVIORAL HEALTH	0	411,864	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	40,557	0		90.00
91.00	09100	EMERGENCY	0	615,487	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	190,933	0		92.00
200.00		Subtotal (see instructions)	0	4,357,739	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	4,357,739	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141306 | Component CCN: 14Z306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V | Date/Time Prepared: 11/15/2012 5:00 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
			1.00	2.00	3.00	4.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.715169	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0.576673	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0.628160	0	0	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.247648	0	0	0		54.00
60.00	06000	LABORATORY	0.234199	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0.083304	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0.298077	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0.404336	0	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0.853207	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.640139	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.672197	0	0	0		73.00
76.00	03020	CARDIAC REHAB	1.013593	0	0	0		76.00
76.01	03550	BEHAVIORAL HEALTH	0.776885	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.804794	0	0	0		90.00
91.00	09100	EMERGENCY	1.264859	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.993239	0	0	0		92.00
200.00		Subtotal (see instructions)		0	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141306 | Component CCN: 14Z306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V | Date/Time Prepared: 11/15/2012 5:00 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: PPS Services (see instructions)	Costs: Cost Services Subject To Ded. & Coins. (see instructions)	Costs: Cost Services Not Subject To Ded. & Coins. (see instructions)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	CARDIAC REHAB	0	0	0		76.00
76.01	03550	BEHAVIORAL HEALTH	0	0	0		76.01
		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		Subtotal (see instructions)	0	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part I | Date/Time Prepared: 11/15/2012 5:00 pm

Title XIX | Hospital

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	161,824	65,271	96,553	713	135.42	30.00
31.00	03100	INTENSIVE CARE UNIT	23,621		23,621	190	124.32	31.00
200.00		Total (lines 30-199)	185,445		120,174	903		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part I Date/Time Prepared: 11/15/2012 5:00 pm

Title XIX | Hospital

		Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
			6.00	7.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	23	3,115		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
200.00		Total (lines 30-199)	23	3,115		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part II Date/Time Prepared: 11/15/2012 5:00 pm

Title XIX | Hospital

		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	45,979	831,841	0.055274	0	0	50.00
51.00	05100	RECOVERY ROOM	10,136	148,311	0.068343	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1,512	525,708	0.002876	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	67,636	6,251,211	0.010820	0	0	54.00
60.00	06000	LABORATORY	31,636	6,976,442	0.004535	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	162	166,739	0.000972	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	17,649	1,447,331	0.012194	0	0	65.00
66.00	06600	PHYSICAL THERAPY	30,364	2,039,320	0.014889	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	29	6,642	0.004366	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,734	695,010	0.026955	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,207	1,176,456	0.010376	0	0	73.00
76.00	03020	CARDIAC REHAB	20,561	133,746	0.153732	0	0	76.00
76.01	03550	BEHAVIORAL HEALTH	31,997	535,360	0.059767	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	14,101	32,038	0.440134	0	0	90.00
91.00	09100	EMERGENCY	34,492	1,387,291	0.024863	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	39,718	255,895	0.155212	0	0	92.00
200.00		Total (lines 50-199)	376,913	22,609,341		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part III Date/Time Prepared: 11/15/2012 5:00 pm

Title XIX | Hospital

		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
200.00		Total (lines 30-199)	0	0	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part III Date/Time Prepared: 11/15/2012 5:00 pm

Title XIX | Hospital

		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	713	0.00	23	0		30.00
31.00	03100	INTENSIVE CARE UNIT	190	0.00	0	0		31.00
200.00		Total (lines 30-199)	903		23	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 11/15/2012 5:00 pm

Title XIX | Hospital

		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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	306,462	0	0	0	306,462	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03550	BEHAVIORAL HEALTH	0	0	0	0	0	76.01
		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)	306,462	0	0	0	306,462	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 11/15/2012 5:00 pm

Title XIX | Hospital

		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	831,841	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	148,311	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	525,708	0.582951	0.000000	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	6,251,211	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	6,976,442	0.000000	0.000000	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	166,739	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,447,331	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,039,320	0.000000	0.000000	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	6,642	0.000000	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	695,010	0.000000	0.000000	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,176,456	0.000000	0.000000	0	73.00
76.00	03020	CARDIAC REHAB	0	133,746	0.000000	0.000000	0	76.00
76.01	03550	BEHAVIORAL HEALTH	0	535,360	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	32,038	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	1,387,291	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	255,895	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	22,609,341			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 11/15/2012 5:00 pm

Title XIX | Hospital

		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
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	CARDIAC REHAB	0	0	0		76.00
76.01	03550	BEHAVIORAL HEALTH	0	0	0		76.01
		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: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 11/15/2012 5:00 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,223	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	713	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)	538	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	241	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)	241	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)	28	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	414	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	241	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)	241	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	117.51	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	117.51	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,738,869	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)	3,290	25.00
26.00	Total swing-bed cost (see instructions)	703,332	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,035,537	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	699,319	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	699,319	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.480779	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)	1,299.85	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,035,537	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,452.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	601,281	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)	601,281	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 11/15/2012 5:00 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	499,898	190	2,631.04	153	402,549	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)	394,873	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,398,703	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	350,021	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	350,021	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	700,042	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)	175	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,452.37	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	254,165	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 11/15/2012 5:00 pm

Title XVIII | Hospital | Cost

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 11/15/2012 5:00 pm

Title XIX | Hospital

	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)	1,223	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	713	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)	538	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)	482	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)	28	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	23	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,738,869	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)	701,368	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,037,501	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,037,501	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,455.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	33,468	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)	33,468	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 11/15/2012 5:00 pm

Title XIX | Hospital

	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	499,898	190	2,631.04	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	33,468	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	3,115	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,115	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	30,353	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)	175	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,455.12	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	254,646	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 11/15/2012 5:00 pm

Title XIX | Hospital

	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	161,824	1,037,501	0.155975	254,646	39,718	90.00
91.00	Nursing School cost	0	1,037,501	0.000000	254,646	0	91.00
92.00	Allied health cost	0	1,037,501	0.000000	254,646	0	92.00
93.00	All other Medical Education	0	1,037,501	0.000000	254,646	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-3 | Date/Time Prepared: 11/15/2012 5:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		284,376		30.00
31.00	03100	INTENSIVE CARE UNIT		231,449		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.715169	30,684	21,944	50.00
51.00	05100	RECOVERY ROOM	0.576673	4,913	2,833	51.00
53.00	05300	ANESTHESIOLOGY	0.628160	21,318	13,391	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.247648	113,461	28,098	54.00
60.00	06000	LABORATORY	0.234199	297,345	69,638	60.00
64.00	06400	INTRAVENOUS THERAPY	0.083304	45,194	3,765	64.00
65.00	06500	RESPIRATORY THERAPY	0.298077	204,625	60,994	65.00
66.00	06600	PHYSICAL THERAPY	0.404336	18,452	7,461	66.00
68.00	06800	SPEECH PATHOLOGY	0.853207	980	836	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.640139	106,603	68,241	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.672197	167,179	112,377	73.00
76.00	03020	CARDIAC REHAB	1.013593	4,726	4,790	76.00
76.01	03550	BEHAVIORAL HEALTH	0.776885	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.804794	0	0	90.00
91.00	09100	EMERGENCY	1.264859	399	505	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.993239	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,015,879	394,873	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)		1,015,879		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-3

Component CCN: 14Z306 | Date/Time Prepared: 11/15/2012 5:00 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.715169	0	0	50.00
51.00	05100	RECOVERY ROOM	0.576673	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.628160	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.247648	28,618	7,087	54.00
60.00	06000	LABORATORY	0.234199	94,568	22,148	60.00
64.00	06400	INTRAVENOUS THERAPY	0.083304	11,503	958	64.00
65.00	06500	RESPIRATORY THERAPY	0.298077	85,999	25,634	65.00
66.00	06600	PHYSICAL THERAPY	0.404336	126,789	51,265	66.00
68.00	06800	SPEECH PATHOLOGY	0.853207	224	191	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.640139	43,004	27,529	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.672197	80,984	54,437	73.00
76.00	03020	CARDIAC REHAB	1.013593	6,060	6,142	76.00
76.01	03550	BEHAVIORAL HEALTH	0.776885	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.804794	0	0	90.00
91.00	09100	EMERGENCY	1.264859	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.993239	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		477,749	195,391	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)		477,749		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141306	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/15/2012 5:00 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,357,739	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,357,739	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,401,316	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	35,302	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,358,764	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	3,007,250	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,007,250	30.00
31.00	Primary payer payments	1,193	31.00
32.00	Subtotal (line 30 minus line 31)	3,006,057	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)	171,355	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	171,355	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	165,621	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	3,177,412	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	3,177,412	40.00
41.00	Interim payments	2,950,945	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)	226,467	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: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E-1 Part I Date/Time Prepared: 11/15/2012 5:00 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,130,000		3,179,003	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	06/29/2012	114,555		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	02/17/2012	17,713	02/17/2012	4,197	3.50
3.51			0	06/29/2012	223,861	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)		96,842		-228,058	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,226,842		2,950,945	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		63,226		226,467	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,290,068		3,177,412	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: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 11/15/2012 5:00 pm

Component CCN: 14Z306 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		821,463		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	06/29/2012	65,183		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	02/17/2012	4,073		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)		61,110		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)		882,573		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		15,588		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		898,161		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 - SWING BEDS

Provider CCN: 141306 | Component CCN: 14Z306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E-2 | Date/Time Prepared: 11/15/2012 5:00 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	707,042	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	197,345	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	482	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	904,387	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	904,387	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	904,387	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,226	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	898,161	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	898,161	0	19.00
20.00	Interim payments	882,573	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	15,588	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141306	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part V Date/Time Prepared: 11/15/2012 5:00 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	1,398,703	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	1,398,703	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,412,690	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,412,690	19.00
20.00	Deductibles (exclude professional component)	140,214	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	1,272,476	22.00
23.00	Coinsurance	1,698	23.00
24.00	Subtotal (line 22 minus line 23)	1,270,778	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	19,290	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	19,290	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	18,298	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,290,068	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	1,290,068	30.00
31.00	Interim payments	1,226,842	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)	63,226	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G | Date/Time Prepared: 11/15/2012 5:00 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,844,663	0	0	0	1.00
2.00	Temporary investments	1,600,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,707,141	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,115,000	0	0	0	6.00
7.00	Inventory	271,538	0	0	0	7.00
8.00	Prepaid expenses	206,051	0	0	0	8.00
9.00	Other current assets	75,000	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)	6,589,393	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	520,386	0	0	0	12.00
13.00	Land improvements	475,384	0	0	0	13.00
14.00	Accumulated depreciation	-206,209	0	0	0	14.00
15.00	Buildings	3,432,958	0	0	0	15.00
16.00	Accumulated depreciation	-2,417,646	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	2,422,836	0	0	0	19.00
20.00	Accumulated depreciation	-2,010,135	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	3,826,930	0	0	0	23.00
24.00	Accumulated depreciation	-3,147,003	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	754,557	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	3,652,058	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,751,033	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	526,394	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,277,427	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	13,518,878	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	451,512	0	0	0	37.00
38.00	Salaries, wages, and fees payable	660,171	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	182,269	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	90,112	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,384,064	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	577,748	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	126,381	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	704,129	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	2,088,193	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	11,430,685				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)	11,430,685	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	13,518,878	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-1 | Date/Time Prepared: 11/15/2012 5:00 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		11,185,964		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		157,142				2.00
3.00	Total (sum of line 1 and line 2)		11,343,106		0		3.00
4.00		0		0			4.00
5.00		0		0			5.00
6.00		0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		11,343,106		0		11.00
12.00	CHANGE IN INTEREST IN NET ASSETS	-87,579		0			12.00
13.00		0		0			13.00
14.00		0		0			14.00
15.00		0		0			15.00
16.00		0		0			16.00
17.00		0		0			17.00
18.00	Total deductions (sum of lines 12-17)		-87,579		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,430,685		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-1 | Date/Time Prepared: 11/15/2012 5:00 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/15/2012 5:00 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	368,568		368,568	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	190,256		190,256	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	558,824		558,824	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	286,291		286,291	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)	286,291		286,291	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	845,115		845,115	17.00
18.00	Ancillary services	1,851,538	19,082,579	20,934,117	18.00
19.00	Outpatient services	6,574	1,668,650	1,675,224	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	27,561	2,190,516	2,218,077	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,730,788	22,941,745	25,672,533	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		13,382,844		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)		13,382,844		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141306 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-3 | Date/Time Prepared: 11/15/2012 5:00 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	25,672,533	1.00
2.00	Less contractual allowances and discounts on patients' accounts	12,428,137	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,244,396	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	13,382,844	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-138,448	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	88,502	6.00
7.00	Income from investments	55,522	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	28,283	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	32,802	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	1,135	16.00
17.00	Revenue from sale of drugs to other than patients	625	17.00
18.00	Revenue from sale of medical records and abstracts	4,120	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	40,965	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	26,676	24.00
24.01	GAIN ON DISPOSAL OF ASSETS	18,960	24.01
25.00	Total other income (sum of lines 6-24)	297,590	25.00
26.00	Total (line 5 plus line 25)	159,142	26.00
27.00	SCHOLARSHIPS	2,000	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2,000	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	157,142	29.00