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: 141347

Period:
From 08/01/2011
To 07/31/2012

Worksheet S
Parts I-III
Date/Time Prepared:
12/26/2012 9:02 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 12/26/2012 Time: 9:02 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CARLINVILLE AREA HOSPITAL (141347) for the cost reporting period beginning 08/01/2011 and ending 07/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	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	106,541	266,716	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	195,092	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	301,633	266,716	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 12/21/2012 9:30 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 20733 NORTH BROAD STREET	PO Box:			1.00
2.00	City: CARLINVILLE	State: IL	Zip Code: 62626-	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	CARLINVILLE AREA HOSPITAL	141347	99914	1	07/01/2005	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	CARLINVILLE AREA HOSPITAL SWING BED	14Z347	99914		07/01/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HOSPITAL-BASED HHA	147249	99914		01/05/1984	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) 1									17.00
17.10	Hospital-Based (CORF) 1									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	08/01/2011	07/31/2012	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	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

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

		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: 141347	Period: From 08/01/2011 To 07/31/2012	Worksheet S-2 Part I Date/Time Prepared: 12/21/2012 9:30 am

		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 additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

	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: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 12/21/2012 9:30 am

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

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

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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 12/21/2012 9:30 am

		1.00	2.00	3.00	
	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	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00

		V	XIX	
		1.00	2.00	
	Title V 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	N	N	N	109.00

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	131,262	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 12/21/2012 9:30 am

		1.00	2.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	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

		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	Y	Y	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10

		1.00	
	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 12/21/2012 9:30 am

		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: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet S-2 Part II | Date/Time Prepared: 12/21/2012 9:30 am

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

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

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

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

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	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	12/06/2012	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: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet S-2 Part II Date/Time Prepared: 12/21/2012 9:30 am

		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				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					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.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
			1.00	2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID	SCHUELLER			41.00
42.00	Enter the employer/company name of the cost report preparer.	EIDE BAILLY				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-557-6161	DSCHUELLER@EIDEBAILLY.COM			43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet S-2 Part II Date/Time Prepared: 12/21/2012 9:30 am

		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	12/06/2012	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.		PARTNER	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: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 12/21/2012 9:30 am

	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	25	9,150	34,728.00		1.00
2.00	HMO						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	34,728.00		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)		25	9,150	34,728.00		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	116.00	0	0			24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10					25.10
26.00	RURAL HEALTH CLINIC	88.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00	Total (sum of lines 14-26)		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: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 12/21/2012 9:30 am

	Cost Center Description	I/P Days / O/P Visits / Trips					
		Title V	Title XVIII	Title XIX	Total All Patients		
		5.00	6.00	7.00	8.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,162	72	1,438		1.00
2.00	HMO		17	0			2.00
3.00	HMO IPF Subprovider		0	0			3.00
4.00	HMO IRF Subprovider		0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	2,033	0	2,035		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	3,195	72	3,501		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	3,195	72	3,501		14.00
15.00	CAH visits	0	11,183	2,442	21,355		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		0	0	0		24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0		25.10
26.00	RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00	Total (sum of lines 14-26)						27.00
28.00	Observation Bed Days	0		0	118		28.00
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				9		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: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 12/21/2012 9:30 am

	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	356	1.00
2.00	HMO					0	2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	131.35	0.00	0	356	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	0.00	0.00	0.00			24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00	0.00	0.00			25.10
26.00	RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00	Total (sum of lines 14-26)	0.00	131.35	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: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 12/21/2012 9:30 am

	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)	24	442		1.00
2.00	HMO				2.00
3.00	HMO IPF Subprovider				3.00
4.00	HMO IRF Subprovider				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF				5.00
6.00	Hospital Adults & Peds. Swing Bed NF				6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00	INTENSIVE CARE UNIT				8.00
9.00	CORONARY CARE UNIT				9.00
10.00	BURN INTENSIVE CARE UNIT				10.00
11.00	SURGICAL INTENSIVE CARE UNIT				11.00
12.00	OTHER SPECIAL CARE (SPECIFY)				12.00
13.00	NURSERY				13.00
14.00	Total (see instructions)	24	442		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
25.10	CMHC - CORF				25.10
26.00	RURAL HEALTH CLINIC				26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days - IRF				31.00
32.00	Labor & delivery days (see instructions)				32.00
33.00	LTCH non-covered days				33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141347	Period: From 08/01/2011 To 07/31/2012	Worksheet S-10 Date/Time Prepared: 12/21/2012 9:30 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.530567	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,038,365	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	650,379	5.00
6.00	Medicaid charges	5,308,500	6.00
7.00	Medicaid cost (line 1 times line 6)	2,816,515	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)	1,127,771	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	94,664	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,127,771	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	424,230	0	424,230	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	225,082	0	225,082	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	225,082	0	225,082	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?		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)	1,235,946	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	408,890	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	827,056	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	438,809	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	663,891	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,791,662	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet A | Date/Time Prepared: 12/21/2012 9:30 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,285,199	1,285,199	1,587,458	2,872,657	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		680,011	680,011	12,902	692,913	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	0	1,346,843	1,346,843	-816,718	530,125	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,098,190	1,762,088	2,860,278	87,072	2,947,350	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	196,126	421,567	617,693	26,168	643,861	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	60,201	60,201	0	60,201	8.00
9.00	00900	HOUSEKEEPING	176,966	28,463	205,429	32,115	237,544	9.00
10.00	01000	DIETARY	129,270	160,145	289,415	20,717	310,132	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	237,905	11,479	249,384	27,404	276,788	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	222,749	163,957	386,706	23,833	410,539	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	198,840	17,373	216,213	13,901	230,114	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	917,251	327,550	1,244,801	107,986	1,352,787	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	213,249	211,763	425,012	19,127	444,139	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	429,873	625,950	1,055,823	69,457	1,125,280	54.00
60.00	06000	LABORATORY	495,814	447,190	943,004	67,274	1,010,278	60.00
65.00	06500	RESPIRATORY THERAPY	181,201	52,634	233,835	21,148	254,983	65.00
66.00	06600	PHYSICAL THERAPY	447,194	41,987	489,181	55,975	545,156	66.00
67.00	06700	OCCUPATIONAL THERAPY	130,734	2,283	133,017	17,257	150,274	67.00
69.00	06900	ELECTROCARDIOLOGY	46,216	12,850	59,066	7,091	66,157	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	64,810	166,394	231,204	12,297	243,501	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	183,575	947,836	1,131,411	24,856	1,156,267	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	126,468	5,864	132,332	19,927	152,259	90.00
91.00	09100	EMERGENCY	737,328	1,564,087	2,301,415	-131,953	2,169,462	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	245	0	245	0	245	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,555,800	1,555,800	-1,555,800	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,234,004	11,899,514	18,133,518	-250,506	17,883,012	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	217,054	33,591	250,645	228,921	479,566	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	14,484	14,484	194.00
194.01	07951	FUND DEVELOPMENT	25,011	6,085	31,096	7,101	38,197	194.01
200.00		TOTAL (SUM OF LINES 118-199)	6,476,069	11,939,190	18,415,259	0	18,415,259	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet A | Date/Time Prepared: 12/21/2012 9:30 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-47,401	2,825,256		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	692,913		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS	-307,258	222,867		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-108,111	2,839,239		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	-65	643,796		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	60,201		8.00
9.00	00900	HOUSEKEEPING	0	237,544		9.00
10.00	01000	DIETARY	-55,971	254,161		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	276,788		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,888	407,651		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	230,114		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,352,787		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-730	443,409		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-5,311	1,119,969		54.00
60.00	06000	LABORATORY	-636	1,009,642		60.00
65.00	06500	RESPIRATORY THERAPY	0	254,983		65.00
66.00	06600	PHYSICAL THERAPY	-1,316	543,840		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	150,274		67.00
69.00	06900	ELECTROCARDIOLOGY	-11,233	54,924		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	243,501		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-13,795	1,142,472		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	-15,886	136,373		90.00
91.00	09100	EMERGENCY	-953,712	1,215,750		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	245		95.00
99.10	09910	CORF	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,524,313	16,358,699		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	479,566		192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	14,484		194.00
194.01	07951	FUND DEVELOPMENT	0	38,197		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-1,524,313	16,890,946		200.00

RECLASSIFICATIONS | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet A-6 | Date/Time Prepared: 12/21/2012 9:30 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS PHYSICIAN SURGEON EXPENSES				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	182,706	25,301	1.00
	TOTALS		182,706	25,301	
	B - RECLASS NONREIMBURSEABLE COSTS				
1.00	NONREIMBURSABLE COSTS CENTERS	194.00	0	14,484	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	14,484	
	C - INSURANCE EXPENSE				
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	60,878	1.00
	TOTALS		0	60,878	
	E - INTEREST EXPENSE RECLASS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,196	1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,548,653	2.00
	TOTALS		0	1,555,849	
	F - RECLASS SALARIES FOR B-1 EMPL BEN				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	45	1.00
	TOTALS		0	45	
	H - DIRECTLY ASSIGN FICA				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	90,710	1.00
2.00	OPERATION OF PLANT	7.00	0	15,121	2.00
3.00	HOUSEKEEPING	9.00	0	13,703	3.00
4.00	DIETARY	10.00	0	9,670	4.00
5.00	NURSING ADMINISTRATION	13.00	0	20,039	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	16,468	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	63,797	7.00
8.00	OPERATING ROOM	50.00	0	15,445	8.00
9.00	NONPHYSICIAN ANESTHETISTS	19.00	0	10,219	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	32,801	10.00
11.00	LABORATORY	60.00	0	37,814	11.00
12.00	RESPIRATORY THERAPY	65.00	0	13,783	12.00
13.00	PHYSICAL THERAPY	66.00	0	33,880	13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	9,892	14.00
15.00	ELECTROCARDIOLOGY	69.00	0	3,409	15.00
16.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,932	16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	13,809	17.00
18.00	CLINIC	90.00	0	12,562	18.00
19.00	EMERGENCY	91.00	0	46,594	19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	13,549	20.00
21.00	FUND DEVELOPMENT	194.01	0	3,419	21.00
	TOTALS		0	481,616	
	I - DIRECTLY ASSIGN HEALTH INSURANCE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	62,602	1.00
2.00	OPERATION OF PLANT	7.00	0	11,047	2.00
3.00	HOUSEKEEPING	9.00	0	18,412	3.00
4.00	DIETARY	10.00	0	11,047	4.00
5.00	NURSING ADMINISTRATION	13.00	0	7,365	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	7,365	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	44,189	7.00
8.00	OPERATING ROOM	50.00	0	3,682	8.00
9.00	NONPHYSICIAN ANESTHETISTS	19.00	0	3,682	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	29,460	10.00
11.00	LABORATORY	60.00	0	29,460	11.00
12.00	RESPIRATORY THERAPY	65.00	0	7,365	12.00
13.00	PHYSICAL THERAPY	66.00	0	22,095	13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	7,365	14.00
15.00	ELECTROCARDIOLOGY	69.00	0	3,682	15.00
16.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,365	16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,047	17.00
18.00	CLINIC	90.00	0	7,365	18.00
19.00	EMERGENCY	91.00	0	29,460	19.00
20.00	FUND DEVELOPMENT	194.01	0	3,682	20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	7,365	21.00
	TOTALS		0	335,102	
500.00	Grand Total: Increases		182,706	2,473,275	500.00

RECLASSIFICATIONS | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet A-6 | Date/Time Prepared: 12/21/2012 9:30 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS PHYSICIAN SURGEON EXPENSES						
1.00	EMERGENCY	91.00	182,706	25,301	0		1.00
	TOTALS		182,706	25,301			
	B - RECLASS NONREIMBURSEABLE COSTS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	9,171	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	5,313	0		2.00
	TOTALS		0	14,484			
	C - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	60,878	0		1.00
	TOTALS		0	60,878			
	E - INTEREST EXPENSE RECLASS						
1.00	INTEREST EXPENSE	113.00	0	1,555,800	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	49	9		2.00
	TOTALS		0	1,555,849			
	F - RECLASS SALARIES FOR B-1 EMPL BEN						
1.00	ADMINISTRATIVE & GENERAL	5.00	45	0	0		1.00
	TOTALS		45	0			
	H - DIRECTLY ASSIGN FICA						
1.00	EMPLOYEE BENEFITS	4.00	0	481,616	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
	TOTALS		0	481,616			
	I - DIRECTLY ASSIGN HEALTH INSURANCE						
1.00	EMPLOYEE BENEFITS	4.00	0	335,102	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
	TOTALS		0	335,102			
500.00	Grand Total: Decreases		182,751	2,473,230			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 12/21/2012 9:30 am

			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	602,527	17,795	0	17,795	19,000	1.00
2.00	Land Improvements	1,320,019	0	0	0	0	2.00
3.00	Buildings and Fixtures	20,499,770	6,440	0	6,440	451,716	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	4,662,300	1,194,591	0	1,194,591	15,264	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	27,084,616	1,218,826	0	1,218,826	485,980	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	27,084,616	1,218,826	0	1,218,826	485,980	10.00

		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,285,199	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	680,011	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,965,210	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	NEW CAP REL COSTS-BLDG & FIXT	21,922,244	0	21,922,244	0.788075	47,976	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	5,895,218	0	5,895,218	0.211925	12,902	2.00
3.00	Total (sum of lines 1-2)	27,817,462	0	27,817,462	1.000000	60,878	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 12/21/2012 9:30 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	601,322	0				1.00
2.00	Land Improvements	1,320,019	0				2.00
3.00	Buildings and Fixtures	20,054,494	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	5,841,627	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	27,817,462	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	27,817,462	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	NEW CAP REL COSTS-BLDG & FIXT	0	1,285,199				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	680,011				2.00
3.00	Total (sum of lines 1-2)	0	1,965,210				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	NEW CAP REL COSTS-BLDG & FIXT	0	0	47,976	2,777,280	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	12,902	680,011	0	2.00
3.00	Total (sum of lines 1-2)	0	0	60,878	3,457,291	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 12/21/2012 9:30 am

	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	NEW CAP REL COSTS-BLDG & FIXT	0	47,976	0	0	2,825,256	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	12,902	0	0	692,913	2.00
3.00	Total (sum of lines 1-2)	0	60,878	0	0	3,518,169	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet A-8 | Date/Time Prepared: 12/21/2012 9:30 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-39,612	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)		0		0.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-852	ADMINISTRATIVE & GENERAL	5.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,875	ADMINISTRATIVE & GENERAL	5.00	7.00
8.00	Television and radio service (chapter 21)		0		0.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-953,712			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	-52,146	DIETARY	10.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients	B	-13,795	DRUGS CHARGED TO PATIENTS	73.00	17.00
18.00	Sale of medical records and abstracts	B	-2,888	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW 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	OCCUPATIONAL THERAPY	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	DIETARY DISCOUNTS	B	-3,825	DIETARY	10.00	33.00
33.01	RADIOLOGY DISCOUNTS	B	-5,311	RADIOLOGY-DIAGNOSTIC	54.00	33.01
33.02	PT PROF FEES	B	-816	PHYSICAL THERAPY	66.00	33.02
33.03	DOMESTIC CHARGES OFFSET	A	-307,258	EMPLOYEE BENEFITS	4.00	33.03
33.04	CONTRACT LAB	B	-636	LABORATORY	60.00	33.04
33.05	SUPPLIES	B	-730	OPERATING ROOM	50.00	33.05
33.06	AHA DUES	A	-1,560	ADMINISTRATIVE & GENERAL	5.00	33.06
33.07			0		0.00	33.07
36.00	TELEVISION DEPRECIATION	A	-5,576	NEW CAP REL COSTS-BLDG & FIXT	1.00	36.00
37.00	LOBBYING COSTS	A	-4,257	ADMINISTRATIVE & GENERAL	5.00	37.00
39.00	MED STAFF RELATIONS	A	-8,858	ADMINISTRATIVE & GENERAL	5.00	39.00
40.00			0		0.00	40.00
41.00			0		0.00	41.00
42.00	ADVERTISING	A	-75,611	ADMINISTRATIVE & GENERAL	5.00	42.00
44.00	TELEPHONE DEPRECIATION	A	-2,213	NEW CAP REL COSTS-BLDG & FIXT	1.00	44.00
44.01	TELEPHONE TRUNKLINE CHARGES	A	-4,991	ADMINISTRATIVE & GENERAL	5.00	44.01
44.02	SPRINGFIELD CLINIC RENT	B	-15,886	CLINIC	90.00	44.02
44.03	PATIENT TELEVISION OFFSET	A	-2,084	ADMINISTRATIVE & GENERAL	5.00	44.03

ADJUSTMENTS TO EXPENSES | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet A-8 | Date/Time Prepared: 12/21/2012 9:30 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
44.04			0		0.00	44.04
44.05			0		0.00	44.05
44.06			0		0.00	44.06
44.07	PROP TAXES-POGUE BLDG	A	-2,496	ADMINISTRATIVE & GENERAL	5.00	44.07
45.00	PHYSICIAN RECRUITMENT	A	-5,261	ADMINISTRATIVE & GENERAL	5.00	45.00
45.01	PLANT OPERATIONS DISCOUNTS	B	-65	OPERATION OF PLANT	7.00	45.01
45.02			0		0.00	45.02
45.03	RECORD REVIEW COSTS	A	-266	ADMINISTRATIVE & GENERAL	5.00	45.03
45.04	DAISY PROGRAM	B	-500	PHYSICAL THERAPY	66.00	45.04
45.05	EKG PROFESSIONAL FEES	A	-11,233	ELECTROCARDIOLOGY	69.00	45.05
45.06			0		0.00	45.06
45.07			0		0.00	45.07
45.08			0		0.00	45.08
45.09			0		0.00	45.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,524,313			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet A-8 | Date/Time Prepared: 12/21/2012 9:30 am

	Cost Center Description	Wkst. A-7 Ref. 5.00		
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	9		1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0		2.00
3.00	Investment income - other (chapter 2)	0		3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0		4.00
5.00	Refunds and rebates of expenses (chapter 8)	0		5.00
6.00	Rental of provider space by suppliers (chapter 8)	0		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0		7.00
8.00	Television and radio service (chapter 21)	0		8.00
9.00	Parking lot (chapter 21)	0		9.00
10.00	Provider-based physician adjustment	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0		11.00
12.00	Related organization transactions (chapter 10)	0		12.00
13.00	Laundry and linen service	0		13.00
14.00	Cafeteria-employees and guests	0		14.00
15.00	Rental of quarters to employee and others	0		15.00
16.00	Sale of medical and surgical supplies to other than patients	0		16.00
17.00	Sale of drugs to other than patients	0		17.00
18.00	Sale of medical records and abstracts	0		18.00
19.00	Nursing school (tuition, fees, books, etc.)	0		19.00
20.00	Vending machines	0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0		26.00
27.00	Depreciation - NEW 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	DIETARY DISCOUNTS	0		33.00
33.01	RADIOLOGY DISCOUNTS	0		33.01
33.02	PT PROF FEES	0		33.02
33.03	DOMESTIC CHARGES OFFSET	0		33.03
33.04	CONTRACT LAB	0		33.04
33.05	SUPPLIES	0		33.05
33.06	AHA DUES	0		33.06
33.07		0		33.07
36.00	TELEVISION DEPRECIATION	9		36.00
37.00	LOBBYING COSTS	0		37.00
39.00	MED STAFF RELATIONS	0		39.00
40.00		0		40.00
41.00		0		41.00
42.00	ADVERTISING	0		42.00
44.00	TELEPHONE DEPRECIATION	9		44.00
44.01	TELEPHONE TRUNKLINE CHARGES	0		44.01
44.02	SPRINGFIELD CLINIC RENT	0		44.02
44.03	PATIENT TELEVISION OFFSET	0		44.03
44.04		0		44.04
44.05		0		44.05
44.06		0		44.06
44.07	PROP TAXES-POGUE BLDG	0		44.07
45.00	PHYSICIAN RECRUITMENT	0		45.00
45.01	PLANT OPERATIONS DISCOUNTS	0		45.01
45.02		0		45.02
45.03	RECORD REVIEW COSTS	0		45.03
45.04	DAISY PROGRAM	0		45.04
45.05	EKG PROFESSIONAL FEES	0		45.05

ADJUSTMENTS TO EXPENSES | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet A-8 | Date/Time Prepared: 12/21/2012 9:30 am

	Cost Center Description	Wkst. A-7 Ref. 5.00		
45.06		0		45.06
45.07		0		45.07
45.08		0		45.08
45.09		0		45.09
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: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 12/21/2012 9:30 am

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		91.00	EMERGENCY	1,406,459	953,712	1.00
2.00		0.00		0	0	2.00
3.00		0.00		0	0	3.00
4.00		0.00		0	0	4.00
5.00		0.00		0	0	5.00
6.00		0.00		0	0	6.00
7.00		0.00		0	0	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00				1,406,459	953,712	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 12/21/2012 9:30 am

		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		452,747	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		452,747		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 12/21/2012 9:30 am

		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: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 12/21/2012 9:30 am

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	953,712		1.00
2.00		0	0		2.00
3.00		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		0	0		10.00
200.00		0	953,712		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 12/21/2012 9:30 am

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)					104	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					0.55	7.00
8.00	Optional travel expense rate per mile					0.55	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	454.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.71	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)	36.36	36.36	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)					33,047	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)					33,047	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)					33,047	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)					72.71	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					56,714	22.00
23.00	Total salary equivalency (see instructions)					56,714	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)					3,781	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)					3,781	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)					57	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					3,838	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)					3,783	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					57	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: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 12/21/2012 9:30 am

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)	72.71	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)	56,714	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	3,783	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)	60,497	63.00
64.00	Total cost of outside supplier services (from your records)	22,575	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	3,781	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	57	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	3,838	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	57	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	57	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: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet B Part I | Date/Time Prepared: 12/21/2012 9:30 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,825,256	2,825,256				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	692,913		692,913			2.00
4.00	00400	EMPLOYEE BENEFITS	222,867	0	0	222,867		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,839,239	570,989	140,705	37,793	3,588,726	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	643,796	394,670	27,615	6,749	1,072,830	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	60,201	0	0	0	60,201	8.00
9.00	00900	HOUSEKEEPING	237,544	18,464	17	6,090	262,115	9.00
10.00	01000	DIETARY	254,161	71,083	16,272	4,449	345,965	10.00
11.00	01100	CAFETERIA	0	71,628	0	0	71,628	11.00
13.00	01300	NURSING ADMINISTRATION	276,788	11,732	607	8,187	297,314	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	407,651	52,916	4,202	7,666	472,435	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	230,114	3,911	34	6,843	240,902	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,352,787	554,805	35,949	31,566	1,975,107	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	443,409	260,374	57,267	7,339	768,389	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,119,969	174,837	336,338	14,794	1,645,938	54.00
60.00	06000	LABORATORY	1,009,642	72,915	10,217	17,063	1,109,837	60.00
65.00	06500	RESPIRATORY THERAPY	254,983	96,526	8,634	6,236	366,379	65.00
66.00	06600	PHYSICAL THERAPY	543,840	141,226	8,350	15,390	708,806	66.00
67.00	06700	OCCUPATIONAL THERAPY	150,274	8,613	0	4,499	163,386	67.00
69.00	06900	ELECTROCARDIOLOGY	54,924	0	7,219	1,590	63,733	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	243,501	40,937	1,077	2,230	287,745	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,142,472	31,878	6,695	6,318	1,187,363	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	136,373	96,130	2,719	4,352	239,574	90.00
91.00	09100	EMERGENCY	1,215,750	109,298	28,641	19,087	1,372,776	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	245	0	0	8	253	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,358,699	2,782,932	692,558	208,249	16,301,402	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9,059	18	0	9,077	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	479,566	30,245	51	13,757	523,619	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	14,484	0	0	0	14,484	194.00
194.01	07951	FUND DEVELOPMENT	38,197	3,020	286	861	42,364	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	16,890,946	2,825,256	692,913	222,867	16,890,946	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet B Part I Date/Time Prepared: 12/21/2012 9:30 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,588,726					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	289,432	0	1,362,262			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,241	0	0	76,442		8.00
9.00	00900	HOUSEKEEPING	70,714	0	13,526	0	346,355	9.00
10.00	01000	DIETARY	93,336	0	52,073	0	13,372	10.00
11.00	01100	CAFETERIA	19,324	0	52,471	0	13,475	11.00
13.00	01300	NURSING ADMINISTRATION	80,211	0	8,594	0	2,207	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	127,455	0	38,764	0	9,955	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	64,992	0	2,865	0	736	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	532,852	0	406,427	42,065	104,370	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	207,299	0	190,739	6,624	48,982	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	444,048	0	128,078	6,287	32,890	54.00
60.00	06000	LABORATORY	299,416	0	53,414	0	13,717	60.00
65.00	06500	RESPIRATORY THERAPY	98,843	0	70,711	0	18,159	65.00
66.00	06600	PHYSICAL THERAPY	191,225	0	103,456	3,385	26,567	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,079	0	6,310	0	1,620	67.00
69.00	06900	ELECTROCARDIOLOGY	17,194	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	77,629	0	29,989	0	7,701	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	320,332	0	23,353	0	5,997	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	64,633	0	70,421	0	18,084	90.00
91.00	09100	EMERGENCY	370,353	0	80,067	18,081	20,561	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	68	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,429,676	0	1,331,258	76,442	338,393	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,449	0	6,636	0	1,704	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	141,264	0	22,156	0	5,690	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	3,908	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	11,429	0	2,212	0	568	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)	3,588,726	0	1,362,262	76,442	346,355	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet B Part I Date/Time Prepared: 12/21/2012 9:30 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			10.00	11.00	13.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	504,746					10.00
11.00	01100	CAFETERIA	264,034	420,932				11.00
13.00	01300	NURSING ADMINISTRATION	0	20,346	408,672			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,620	0	677,229		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	4,521	8,952	9,151	332,119	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	240,712	111,674	221,123	43,476	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	16,684	33,033	26,944	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	332,119	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,673	0	166,862	0	54.00
60.00	06000	LABORATORY	0	44,625	0	122,864	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	15,553	0	24,493	0	65.00
66.00	06600	PHYSICAL THERAPY	0	31,468	0	46,843	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,540	0	15,282	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	3,934	0	12,989	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,189	0	22,387	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,519	26,766	51,090	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	12,072	23,904	5,156	0	90.00
91.00	09100	EMERGENCY	0	47,926	94,894	80,535	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	504,746	403,344	408,672	628,072	332,119	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	15,327	0	49,157	0	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	2,261	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)	504,746	420,932	408,672	677,229	332,119	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet B Part I Date/Time Prepared: 12/21/2012 9:30 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,677,806	-1,023	3,676,783		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,298,694	0	1,298,694		50.00
53.00	05300	ANESTHESIOLOGY	332,119	0	332,119		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,459,776	0	2,459,776		54.00
60.00	06000	LABORATORY	1,643,873	1,023	1,644,896		60.00
65.00	06500	RESPIRATORY THERAPY	594,138	0	594,138		65.00
66.00	06600	PHYSICAL THERAPY	1,111,750	0	1,111,750		66.00
67.00	06700	OCCUPATIONAL THERAPY	240,217	0	240,217		67.00
69.00	06900	ELECTROCARDIOLOGY	97,850	0	97,850		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	432,640	0	432,640		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,628,420	0	1,628,420		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	433,844	0	433,844		90.00
91.00	09100	EMERGENCY	2,085,193	0	2,085,193		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	321	0	321		95.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,036,641	0	16,036,641		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	19,866	0	19,866		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	757,213	0	757,213		192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	18,392	0	18,392		194.00
194.01	07951	FUND DEVELOPMENT	58,834	0	58,834		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)	16,890,946	0	16,890,946		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet B Part II | Date/Time Prepared: 12/21/2012 9:30 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	36,317	570,989	140,705	748,011	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	919	0	0	919	0	6.00
7.00	00700	OPERATION OF PLANT	145	394,670	27,615	422,430	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	18,464	17	18,481	0	9.00
10.00	01000	DIETARY	1,538	71,083	16,272	88,893	0	10.00
11.00	01100	CAFETERIA	0	71,628	0	71,628	0	11.00
13.00	01300	NURSING ADMINISTRATION	44	11,732	607	12,383	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,533	52,916	4,202	68,651	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	3,911	34	3,945	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,340	554,805	35,949	632,094	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	143,865	260,374	57,267	461,506	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,938	174,837	336,338	551,113	0	54.00
60.00	06000	LABORATORY	58,981	72,915	10,217	142,113	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,305	96,526	8,634	111,465	0	65.00
66.00	06600	PHYSICAL THERAPY	0	141,226	8,350	149,576	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,613	0	8,613	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	7,219	7,219	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	40,937	1,077	42,014	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	84,408	31,878	6,695	122,981	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	96,130	2,719	98,849	0	90.00
91.00	09100	EMERGENCY	1,317	109,298	28,641	139,256	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	426,650	2,782,932	692,558	3,902,140	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9,059	18	9,077	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	30,245	51	30,296	0	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	3,020	286	3,306	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	426,650	2,825,256	692,913	3,944,819	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet B Part II | Date/Time Prepared: 12/21/2012 9:30 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	748,011					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	919				6.00
7.00	00700	OPERATION OF PLANT	60,327	161	482,918			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,385	0	0	3,385		8.00
9.00	00900	HOUSEKEEPING	14,739	8	4,795	0	38,023	9.00
10.00	01000	DIETARY	19,454	29	18,460	0	1,468	10.00
11.00	01100	CAFETERIA	4,028	29	18,601	0	1,479	11.00
13.00	01300	NURSING ADMINISTRATION	16,719	5	3,047	0	242	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,566	22	13,742	0	1,093	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	13,546	2	1,016	0	81	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	111,067	224	144,077	1,863	11,459	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,208	106	67,616	293	5,377	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	92,554	71	45,403	278	3,611	54.00
60.00	06000	LABORATORY	62,408	30	18,935	0	1,506	60.00
65.00	06500	RESPIRATORY THERAPY	20,602	39	25,067	0	1,993	65.00
66.00	06600	PHYSICAL THERAPY	39,858	58	36,675	150	2,917	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,188	4	2,237	0	178	67.00
69.00	06900	ELECTROCARDIOLOGY	3,584	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,180	17	10,631	0	845	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,768	13	8,279	0	658	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	13,472	39	24,964	0	1,985	90.00
91.00	09100	EMERGENCY	77,194	45	28,383	801	2,257	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	14	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	714,861	902	471,928	3,385	37,149	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	510	4	2,352	0	187	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	29,444	12	7,854	0	625	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	814	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	2,382	1	784	0	62	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)	748,011	919	482,918	3,385	38,023	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet B Part II Date/Time Prepared: 12/21/2012 9:30 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			10.00	11.00	13.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	128,304					10.00
11.00	01100	CAFETERIA	67,116	162,881				11.00
13.00	01300	NURSING ADMINISTRATION	0	7,873	40,269			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,075	0	121,149		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	1,750	882	1,637	22,859	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	61,188	43,211	21,789	7,777		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,456	3,255	4,820		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,804	0	29,855		54.00
60.00	06000	LABORATORY	0	17,268	0	21,978		60.00
65.00	06500	RESPIRATORY THERAPY	0	6,018	0	4,381		65.00
66.00	06600	PHYSICAL THERAPY	0	12,177	0	8,379		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,692	0	2,734		67.00
69.00	06900	ELECTROCARDIOLOGY	0	1,522	0	2,323		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,782	0	4,005		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,231	2,637	9,139		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000	CLINIC	0	4,671	2,355	922		90.00
91.00	09100	EMERGENCY	0	18,545	9,351	14,406		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
99.10	09910	CORF	0	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	128,304	156,075	40,269	112,356	0	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	5,931	0	8,793		192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0		194.00
194.01	07951	FUND DEVELOPMENT	0	875	0	0		194.01
200.00		Cross Foot Adjustments					22,859	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	128,304	162,881	40,269	121,149	22,859	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet B Part II | Date/Time Prepared: 12/21/2012 9:30 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,034,749	0	1,034,749		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	592,637	0	592,637		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	736,689	0	736,689		54.00
60.00	06000	LABORATORY	264,238	0	264,238		60.00
65.00	06500	RESPIRATORY THERAPY	169,565	0	169,565		65.00
66.00	06600	PHYSICAL THERAPY	249,790	0	249,790		66.00
67.00	06700	OCCUPATIONAL THERAPY	26,646	0	26,646		67.00
69.00	06900	ELECTROCARDIOLOGY	14,648	0	14,648		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	76,474	0	76,474		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	215,706	0	215,706		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	147,257	0	147,257		90.00
91.00	09100	EMERGENCY	290,238	0	290,238		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	14	0	14		95.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,818,651	0	3,818,651		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	12,130	0	12,130		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	82,955	0	82,955		192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	814	0	814		194.00
194.01	07951	FUND DEVELOPMENT	7,410	0	7,410		194.01
200.00		Cross Foot Adjustments	22,859	0	22,859		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	3,944,819	0	3,944,819		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet B-1 | Date/Time Prepared: 12/21/2012 9:30 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	57,075					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		680,011				2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	6,476,024			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,535	138,085	1,098,145	-3,588,726	13,302,220	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	7,973	27,101	196,126	0	1,072,830	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	60,201	8.00
9.00	00900	HOUSEKEEPING	373	17	176,966	0	262,115	9.00
10.00	01000	DIETARY	1,436	15,969	129,270	0	345,965	10.00
11.00	01100	CAFETERIA	1,447	0	0	0	71,628	11.00
13.00	01300	NURSING ADMINISTRATION	237	596	237,905	0	297,314	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,069	4,124	222,749	0	472,435	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79	33	198,840	0	240,902	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,208	35,280	917,251	0	1,975,107	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,260	56,201	213,249	0	768,389	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,532	330,073	429,873	0	1,645,938	54.00
60.00	06000	LABORATORY	1,473	10,027	495,814	0	1,109,837	60.00
65.00	06500	RESPIRATORY THERAPY	1,950	8,473	181,201	0	366,379	65.00
66.00	06600	PHYSICAL THERAPY	2,853	8,195	447,194	0	708,806	66.00
67.00	06700	OCCUPATIONAL THERAPY	174	0	130,734	0	163,386	67.00
69.00	06900	ELECTROCARDIOLOGY	0	7,085	46,216	0	63,733	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	827	1,057	64,810	0	287,745	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	644	6,570	183,575	0	1,187,363	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,942	2,668	126,468	0	239,574	90.00
91.00	09100	EMERGENCY	2,208	28,108	554,622	0	1,372,776	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	245	0	253	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	56,220	679,662	6,051,253	-3,588,726	12,712,676	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	18	0	0	9,077	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	611	50	399,760	0	523,619	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	14,484	194.00
194.01	07951	FUND DEVELOPMENT	61	281	25,011	0	42,364	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)	2,825,256	692,913	222,867		3,588,726	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	49.500762	1.018973	0.034414		0.269784	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		748,011	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.056232	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet B-1 | Date/Time Prepared: 12/21/2012 9:30 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	45,540					6.00
7.00	00700	OPERATION OF PLANT	7,973	37,567				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	102,036			8.00
9.00	00900	HOUSEKEEPING	373	373	0	37,194		9.00
10.00	01000	DIETARY	1,436	1,436	0	1,436	30,126	10.00
11.00	01100	CAFETERIA	1,447	1,447	0	1,447	15,759	11.00
13.00	01300	NURSING ADMINISTRATION	237	237	0	237	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,069	1,069	0	1,069	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79	79	0	79	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,208	11,208	56,148	11,208	14,367	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,260	5,260	8,842	5,260	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,532	3,532	8,392	3,532	0	54.00
60.00	06000	LABORATORY	1,473	1,473	0	1,473	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,950	1,950	0	1,950	0	65.00
66.00	06600	PHYSICAL THERAPY	2,853	2,853	4,519	2,853	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	174	174	0	174	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	827	827	0	827	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	644	644	0	644	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,942	1,942	0	1,942	0	90.00
91.00	09100	EMERGENCY	2,208	2,208	24,135	2,208	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	44,685	36,712	102,036	36,339	30,126	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	183	0	183	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	611	611	0	611	0	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	61	61	0	61	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)	0	1,362,262	76,442	346,355	504,746	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	36.262198	0.749167	9.312120	16.754498	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	919	482,918	3,385	38,023	128,304	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.020180	12.854846	0.033175	1.022289	4.258913	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet B-1 | Date/Time Prepared: 12/21/2012 9:30 am

		Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			11.00	13.00	16.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	9,310					11.00
13.00	01300	NURSING ADMINISTRATION	450	94,952				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	633	0	33,063,577			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	100	2,080	446,774	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,470	51,376	2,122,550			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	369	7,675	1,315,431	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	789	0	8,146,848	0		54.00
60.00	06000	LABORATORY	987	0	5,998,348	0		60.00
65.00	06500	RESPIRATORY THERAPY	344	0	1,195,787	0		65.00
66.00	06600	PHYSICAL THERAPY	696	0	2,286,928	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	211	0	746,101	0		67.00
69.00	06900	ELECTROCARDIOLOGY	87	0	634,131	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	159	0	1,092,968	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	299	6,219	2,494,281	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000	CLINIC	267	5,554	251,738	0		90.00
91.00	09100	EMERGENCY	1,060	22,048	3,931,820	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
99.10	09910	CORF	0	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,921	94,952	30,663,705	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	339	0	2,399,872	0		192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0		194.00
194.01	07951	FUND DEVELOPMENT	50	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)	420,932	408,672	677,229	332,119		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	45.212889	4.303985	0.020483	3,321.190000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	162,881	40,269	121,149	22,859		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	17.495274	0.424098	0.003664	228.590000		205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet B-2 | Date/Time Prepared: 12/21/2012 9:30 am

		Description	Worksheet Part	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		LABORATORY	1	60.00	1,023	5.00
6.00		ADULTS AND PEDIATRICS	1	30.00	-1,023	6.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet C Part I Date/Time Prepared: 12/21/2012 9:30 am

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	3,676,783		3,676,783	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,298,694		1,298,694	0	0	50.00
53.00	05300	ANESTHESIOLOGY	332,119		332,119	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,459,776		2,459,776	0	0	54.00
60.00	06000	LABORATORY	1,644,896		1,644,896	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	594,138	0	594,138	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,111,750	0	1,111,750	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	240,217	0	240,217	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	97,850		97,850	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	432,640		432,640	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,628,420		1,628,420	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	433,844		433,844	0	0	90.00
91.00	09100	EMERGENCY	2,085,193		2,085,193	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	120,707		120,707		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	321		321	0	0	95.00
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	16,157,348	0	16,157,348	0	0	200.00
201.00		Less Observation Beds	120,707		120,707		0	201.00
202.00		Total (see instructions)	16,036,641	0	16,036,641	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet C Part I Date/Time Prepared: 12/21/2012 9:30 am

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	1,977,903		1,977,903			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,510	1,261,886	1,287,396	1.008776	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	7,400	437,989	445,389	0.745683	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	601,107	7,403,739	8,004,846	0.307286	0.000000	54.00
60.00	06000	LABORATORY	754,031	5,129,264	5,883,295	0.279588	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	217,094	966,644	1,183,738	0.501917	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	467,966	1,803,499	2,271,465	0.489442	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	493,203	248,403	741,606	0.323915	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	36,494	590,082	626,576	0.156166	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	465,235	591,003	1,056,238	0.409605	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,131,413	1,329,832	2,461,245	0.661625	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	1,525	245,545	247,070	1.755956	0.000000	90.00
91.00	09100	EMERGENCY	42,637	3,862,942	3,905,579	0.533901	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	9,468	123,663	133,131	0.906678	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	6,230,986	23,994,491	30,225,477			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,230,986	23,994,491	30,225,477			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet C Part I Date/Time Prepared: 12/21/2012 9:30 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
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
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
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		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
99.10	09910	CORF		99.10
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet D Part II Date/Time Prepared: 12/21/2012 9:30 am

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	592,637	1,287,396	0.460338	22,103	10,175	50.00
53.00	05300	ANESTHESIOLOGY	0	445,389	0.000000	6,010	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	736,689	8,004,846	0.092030	433,753	39,918	54.00
60.00	06000	LABORATORY	264,238	5,883,295	0.044913	477,734	21,456	60.00
65.00	06500	RESPIRATORY THERAPY	169,565	1,183,738	0.143245	89,878	12,875	65.00
66.00	06600	PHYSICAL THERAPY	249,790	2,271,465	0.109969	75,404	8,292	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,646	741,606	0.035930	37,194	1,336	67.00
69.00	06900	ELECTROCARDIOLOGY	14,648	626,576	0.023378	23,054	539	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	76,474	1,056,238	0.072402	215,312	15,589	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	215,706	2,461,245	0.087641	386,163	33,844	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	147,257	247,070	0.596013	0	0	90.00
91.00	09100	EMERGENCY	290,238	3,905,579	0.074314	15,895	1,181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	133,131	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,783,888	28,247,574		1,782,500	145,205	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet D Part IV Date/Time Prepared: 12/21/2012 9:30 am

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	50.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	54.00
60.00	06000	LABORATORY		0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	89.00
90.00	09000	CLINIC		0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet D Part IV Date/Time Prepared: 12/21/2012 9:30 am

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	1,287,396	0.000000	0.000000	22,103	50.00
53.00	05300	ANESTHESIOLOGY	0	445,389	0.000000	0.000000	6,010	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,004,846	0.000000	0.000000	433,753	54.00
60.00	06000	LABORATORY	0	5,883,295	0.000000	0.000000	477,734	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,183,738	0.000000	0.000000	89,878	65.00
66.00	06600	PHYSICAL THERAPY	0	2,271,465	0.000000	0.000000	75,404	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	741,606	0.000000	0.000000	37,194	67.00
69.00	06900	ELECTROCARDIOLOGY	0	626,576	0.000000	0.000000	23,054	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,056,238	0.000000	0.000000	215,312	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,461,245	0.000000	0.000000	386,163	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	247,070	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	3,905,579	0.000000	0.000000	15,895	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	133,131	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	28,247,574			1,782,500	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet D Part IV | Date/Time Prepared: 12/21/2012 9:30 am

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
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
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
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
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet D Part V Date/Time Prepared: 12/21/2012 9:30 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			1.00	2.00	3.00	4.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.008776	0	678,068	0		50.00
53.00	05300	ANESTHESIOLOGY	0.745683	0	268,932	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.307286	0	3,267,923	0		54.00
60.00	06000	LABORATORY	0.279588	0	2,728,925	0		60.00
65.00	06500	RESPIRATORY THERAPY	0.501917	0	168,486	0		65.00
66.00	06600	PHYSICAL THERAPY	0.489442	0	614,105	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.323915	0	55,975	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0.156166	0	359,456	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.409605	0	309,977	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.661625	0	671,211	158		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	09000	CLINIC	1.755956	0	168,622	0		90.00
91.00	09100	EMERGENCY	0.533901	0	1,456,216	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.906678	0	57,088	0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	10,804,984	158		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	10,804,984	158		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet D Part V Date/Time Prepared: 12/21/2012 9:30 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs PPS Services (see inst.)	Costs Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	684,019	0		50.00
53.00	05300	ANESTHESIOLOGY	0	200,538	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,004,187	0		54.00
60.00	06000	LABORATORY	0	762,975	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	84,566	0		65.00
66.00	06600	PHYSICAL THERAPY	0	300,569	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,131	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	56,135	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	126,968	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	444,090	105		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	296,093	0		90.00
91.00	09100	EMERGENCY	0	777,475	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	51,760	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES		0			95.00
200.00		Subtotal (see instructions)	0	4,807,506	105		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	4,807,506	105		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141347 | Component CCN: 14Z347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet D Part V | Date/Time Prepared: 12/21/2012 9:30 am

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 inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			1.00	2.00	3.00	4.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.008776	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0.745683	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.307286	0	0	0		54.00
60.00	06000	LABORATORY	0.279588	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0.501917	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0.489442	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.323915	0	0	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0.156166	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.409605	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.661625	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	09000	CLINIC	1.755956	0	0	0		90.00
91.00	09100	EMERGENCY	0.533901	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.906678	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
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: 141347 | Component CCN: 14Z347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet D Part V Date/Time Prepared: 12/21/2012 9:30 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: PPS Services (see inst.)	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
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
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
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
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES		0			95.00
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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet D-1 | Date/Time Prepared: 12/21/2012 9:30 am

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)	3,619	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,556	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)	1,438	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	801	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)	1,234	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	4	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)	24	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,162	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)	801	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)	1,232	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	119.84	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	121.04	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,676,783	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)	479	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)	2,905	25.00
26.00	Total swing-bed cost (see instructions)	2,085,087	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,591,696	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,346,500	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,346,500	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.182099	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)	936.37	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)	1,591,696	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,022.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,188,668	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,188,668	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet D-1 | Date/Time Prepared: 12/21/2012 9:30 am

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						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)	743,473	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,932,141	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)	819,383	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,260,274	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	2,079,657	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)	118	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,022.94	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	120,707	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet D-1 | Date/Time Prepared: 12/21/2012 9:30 am

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet D-3 | Date/Time Prepared: 12/21/2012 9:30 am

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		864,528		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.008776	22,103	22,297	50.00
53.00	05300	ANESTHESIOLOGY	0.745683	6,010	4,482	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.307286	433,753	133,286	54.00
60.00	06000	LABORATORY	0.279588	477,734	133,569	60.00
65.00	06500	RESPIRATORY THERAPY	0.501917	89,878	45,111	65.00
66.00	06600	PHYSICAL THERAPY	0.489442	75,404	36,906	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.323915	37,194	12,048	67.00
69.00	06900	ELECTROCARDIOLOGY	0.156166	23,054	3,600	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.409605	215,312	88,193	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.661625	386,163	255,495	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	1.755956	0	0	90.00
91.00	09100	EMERGENCY	0.533901	15,895	8,486	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.906678	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,782,500	743,473	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)		1,782,500		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141347 | Component CCN: 14Z347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet D-3 | Date/Time Prepared: 12/21/2012 9:30 am

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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.008776	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.745683	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.307286	117,345	36,058	54.00
60.00	06000	LABORATORY	0.279588	176,791	49,429	60.00
65.00	06500	RESPIRATORY THERAPY	0.501917	110,981	55,703	65.00
66.00	06600	PHYSICAL THERAPY	0.489442	379,125	185,560	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.323915	444,353	143,933	67.00
69.00	06900	ELECTROCARDIOLOGY	0.156166	4,627	723	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.409605	220,859	90,465	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.661625	649,109	429,467	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	1.755956	0	0	90.00
91.00	09100	EMERGENCY	0.533901	4,298	2,295	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.906678	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		2,107,488	993,633	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)		2,107,488		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141347	Period: From 08/01/2011 To 07/31/2012	Worksheet E Part B Date/Time Prepared: 12/21/2012 9:30 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,807,611	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)	4,807,611	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)	4,855,687	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)	39,782	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,606,520	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)	3,209,385	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)	3,209,385	30.00
31.00	Primary payer payments	212	31.00
32.00	Subtotal (line 30 minus line 31)	3,209,173	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)	361,761	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	361,761	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	342,601	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	3,570,934	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)	3,570,934	40.00
41.00	Interim payments	3,304,218	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)	266,716	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: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet E-1 Part I | Date/Time Prepared: 12/21/2012 9:30 am

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		1,545,421		3,086,113	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	03/02/2012	14,152	03/02/2012	108,620	3.01
3.02		06/29/2012	38,363	06/29/2012	109,485	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		52,515		218,105	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)		1,597,936		3,304,218	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		106,541		266,716	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,704,477		3,570,934	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: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet E-1 Part I | Date/Time Prepared: 12/21/2012 9:30 am

Component CCN: 14Z347 | 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		2,775,307		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	03/02/2012	27,298		0	3.01
3.02		06/29/2012	47,994		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		75,292		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)		2,850,599		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		195,092		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,045,691		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: 141347 | Component CCN: 14Z347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet E-2 | Date/Time Prepared: 12/21/2012 9:30 am

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)	2,100,454	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)	1,003,569	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	2,033	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)	3,104,023	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	3,104,023	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)	3,104,023	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	58,332	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)	3,045,691	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)	3,045,691	0	19.00
20.00	Interim payments	2,850,599	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)	195,092	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: 141347	Period: From 08/01/2011 To 07/31/2012	Worksheet E-3 Part V Date/Time Prepared: 12/21/2012 9:30 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	1,932,141	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)	1,932,141	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,951,462	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)	1,951,462	19.00
20.00	Deductibles (exclude professional component)	292,404	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	1,659,058	22.00
23.00	Coinsurance	1,710	23.00
24.00	Subtotal (line 22 minus line 23)	1,657,348	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	47,129	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	47,129	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	42,747	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,704,477	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)	1,704,477	30.00
31.00	Interim payments	1,597,936	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)	106,541	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: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet G | Date/Time Prepared: 12/21/2012 9:30 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,222,083	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,127,943	0	0	0	4.00
5.00	Other receivable	526,865	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-742,000	0	0	0	6.00
7.00	Inventory	193,910	0	0	0	7.00
8.00	Prepaid expenses	200,160	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,528,961	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	601,322	0	0	0	12.00
13.00	Land improvements	1,320,020	0	0	0	13.00
14.00	Accumulated depreciation	-186,599	0	0	0	14.00
15.00	Buildings	20,000,904	0	0	0	15.00
16.00	Accumulated depreciation	-2,435,712	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,268,102	0	0	0	23.00
24.00	Accumulated depreciation	-2,067,807	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	627,115	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	23,127,345	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,133,420	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	974,059	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,107,479	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	33,763,785	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	667,334	0	0	0	37.00
38.00	Salaries, wages, and fees payable	551,822	0	0	0	38.00
39.00	Payroll taxes payable	97,962	0	0	0	39.00
40.00	Notes and loans payable (short term)	396,266	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	0	0	0	0	43.00
44.00	Other current liabilities	158,363	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,871,747	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	18,735,095	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	18,735,095	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	20,606,842	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	13,156,943				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)	13,156,943	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	33,763,785	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet G-1 | Date/Time Prepared: 12/21/2012 9:30 am

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		12,935,259		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		229,651				2.00
3.00	Total (sum of line 1 and line 2)		13,164,910		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)		13,164,910		0		11.00
12.00		0		0			12.00
13.00	DECREASE IN PERM RESTRICTED	7,967		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)		7,967		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,156,943		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet G-1 | Date/Time Prepared: 12/21/2012 9:30 am

		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		0		0			12.00
13.00	DECREASE IN PERM RESTRICTED	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: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet G-2 Parts I & II Date/Time Prepared: 12/21/2012 9:30 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,346,500		1,346,500	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	776,050		776,050	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)	2,122,550		2,122,550	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,122,550		2,122,550	17.00
18.00	Ancillary services	4,337,290	26,603,843	30,941,133	18.00
19.00	Outpatient services	0	0	0	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	0	0	0	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,459,840	26,603,843	33,063,683	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,415,259		29.00
30.00	PROVISION FOR BAD DEBTS	1,235,946			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)		1,235,946		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)		19,651,205		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141347 | Period: From 08/01/2011 To 07/31/2012 | Worksheet G-3 | Date/Time Prepared: 12/21/2012 9:30 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	33,063,683	1.00
2.00	Less contractual allowances and discounts on patients' accounts	14,151,449	2.00
3.00	Net patient revenues (line 1 minus line 2)	18,912,234	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	19,651,205	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-738,971	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	205,614	6.00
7.00	Income from investments	50,083	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	22,147	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	52,146	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	23,055	22.00
23.00	Governmental appropriations	0	23.00
24.00	RENT	12,750	24.00
24.01	SALES TO NON PATIENTS	4,934	24.01
24.02	PHYSICAL THERAPY - NON PATIENTS	500	24.02
24.03	OTHER	21,215	24.03
24.04	GAIN FROM DISPOSAL OF PROPERTY AND E	254,398	24.04
24.05	TRANSFER FROM RELATED PARTY - FOUNDA	286,369	24.05
24.06	GRANTS	35,411	24.06
25.00	Total other income (sum of lines 6-24)	968,622	25.00
26.00	Total (line 5 plus line 25)	229,651	26.00
27.00		0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	229,651	29.00