This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141306	Period: From 07/01/2012 To 06/30/2013	Worksheet S Parts I-III Date/Time Prepared: 10/29/2013 1:30 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 10/29/2013 Time: 1:30 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [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 COMMUNITY MEMORIAL HOSPITAL (141306) for the cost reporting period beginning 07/01/2012 and ending 06/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	183,427	171,192	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	138,473	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	321,900	171,192	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 10/29/2013 1:22 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 400 CALDWELL STREET	PO Box:			1.00
2.00	City: STAUNTON	State: IL	Zip Code: 62088-1499	County: MACOUPIN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	COMMUNITY MEMORIAL HOSPITAL	141306	99914	1	08/01/2000	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	COMMUNITY MEMORIAL HOSPITAL - SWB	14Z306	99914		08/01/2000	N	O	N	7.00
8.00	Swing Beds - NF									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									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2012	06/30/2013	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I Date/Time Prepared: 10/29/2013 1:22 pm

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.	N	N	39.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I Date/Time Prepared: 10/29/2013 1:22 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 10/29/2013 1:22 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 10/29/2013 1:22 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	58,320	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	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	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141306	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 10/29/2013 1:22 pm

							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						333,261	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 10/29/2013 1:22 pm

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	09/11/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 10/29/2013 1:22 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				Y	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				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					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.	BRIAN	ENGELKE	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY MEMORIAL HOSPITAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-635-4242	BENGELKE@STAUNTONHOSPITAL.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 10/29/2013 1:22 pm

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	09/11/2013			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		CFO		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I Date/Time Prepared: 10/29/2013 1:22 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	21	7,665	7,632.00	0	1.00
2.00	HMO						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	7,632.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	7,632.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 10/29/2013 1:22 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	318	5	397			1.00
2.00	HMO	0	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	446	0	467			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	11			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	764	5	875			7.00
8.00	INTENSIVE CARE UNIT	112	5	134			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)	876	10	1,009	0.00	118.94	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	118.94	27.00
28.00	Observation Bed Days		0	146			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 10/29/2013 1:22 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	149	7	191	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	0	149	7	191	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-10 | Date/Time Prepared: 10/29/2013 1:22 pm

		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)	0.511591	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,624,022	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	3,167,121	6.00
7.00	Medicaid cost (line 1 times line 6)	1,620,271	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	70,712	24,252	94,964	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	36,176	12,407	48,583	21.00
22.00	Partial payment by patients approved for charity care	1,482	2,357	3,839	22.00
23.00	Cost of charity care (line 21 minus line 22)	34,694	10,050	44,744	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,227,607	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	206,617	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	1,020,990	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	522,329	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	567,073	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	567,073	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A | Date/Time Prepared: 10/29/2013 1:22 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		545,398	545,398	-515,319	30,079	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1		0	0	13,860	13,860	1.01
1.02	00103	CAP REL COSTS-BLDG & FIXT- BLDG 2		0	0	90,440	90,440	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	453,280	453,280	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	3,872	3,872	3.00
4.00	00400	EMPLOYEE BENEFITS	0	1,232,320	1,232,320	140,794	1,373,114	4.00
5.01	00510	OTHER A&G	830,834	813,194	1,644,028	-701,545	942,483	5.01
5.02	00520	DATA PROCESSING	0	0	0	269,002	269,002	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	0	0	247,096	247,096	5.03
7.00	00700	OPERATION OF PLANT	163,167	339,982	503,149	828	503,977	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,192	8,845	32,037	0	32,037	8.00
9.00	00900	HOUSEKEEPING	160,044	15,879	175,923	0	175,923	9.00
10.00	01000	DIETARY	121,365	89,843	211,208	-93,209	117,999	10.00
11.00	01100	CAFETERIA	0	0	0	93,209	93,209	11.00
13.00	01300	NURSING ADMINISTRATION	233,572	16,543	250,115	0	250,115	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	161,652	34,393	196,045	0	196,045	16.00
17.00	01700	SOCIAL SERVICE	57,253	0	57,253	0	57,253	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	284,992	284,992	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	672,670	42,661	715,331	0	715,331	30.00
31.00	03100	INTENSIVE CARE UNIT	238,324	0	238,324	0	238,324	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	189,605	52,966	242,571	0	242,571	50.00
51.00	05100	RECOVERY ROOM	34,479	0	34,479	0	34,479	51.00
53.00	05300	ANESTHESIOLOGY	0	291,519	291,519	-284,992	6,527	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	415,840	521,706	937,546	0	937,546	54.00
60.00	06000	LABORATORY	501,667	512,903	1,014,570	0	1,014,570	60.00
64.00	06400	INTRAVENOUS THERAPY	0	9,816	9,816	0	9,816	64.00
65.00	06500	RESPIRATORY THERAPY	168,638	148,847	317,485	-23,224	294,261	65.00
66.00	06600	PHYSICAL THERAPY	33,051	578,333	611,384	7,667	619,051	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	25,018	25,018	0	25,018	67.00
68.00	06800	SPEECH PATHOLOGY	0	14,857	14,857	0	14,857	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	92,733	167,150	259,883	23,224	283,107	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	156,503	515,361	671,864	0	671,864	73.00
76.00	03020	CARDIAC REHAB	56,485	646	57,131	0	57,131	76.00
76.01	03021	BEHAVIORAL HEALTH	118,488	105,684	224,172	0	224,172	76.01
76.02	03023	WOUND CLINIC	0	104,875	104,875	0	104,875	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	25,277	9,574	34,851	0	34,851	90.00
91.00	09100	EMERGENCY	411,895	1,380,467	1,792,362	0	1,792,362	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	8	8	-8	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		4,270	4,270	-4,270	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,866,734	7,583,058	12,449,792	5,697	12,455,489	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	670,750	131,586	802,336	-5,697	796,639	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MEDICAL OFFICE BUILDING	0	104,464	104,464	0	104,464	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	5,537,484	7,819,108	13,356,592	0	13,356,592	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A | Date/Time Prepared: 10/29/2013 1:22 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	30,079		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	13,860		1.01
1.02	00103	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	90,440		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-90,806	362,474		2.00
3.00	00300	OTHER CAP REL COSTS	-3,872	0		3.00
4.00	00400	EMPLOYEE BENEFITS	-6,427	1,366,687		4.00
5.01	00510	OTHER A&G	-166,698	775,785		5.01
5.02	00520	DATA PROCESSING	0	269,002		5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	-6,350	240,746		5.03
7.00	00700	OPERATION OF PLANT	0	503,977		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	32,037		8.00
9.00	00900	HOUSEKEEPING	0	175,923		9.00
10.00	01000	DIETARY	-630	117,369		10.00
11.00	01100	CAFETERIA	-32,967	60,242		11.00
13.00	01300	NURSING ADMINISTRATION	-1,041	249,074		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,503	187,542		16.00
17.00	01700	SOCIAL SERVICE	0	57,253		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	284,992		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	715,331		30.00
31.00	03100	INTENSIVE CARE UNIT	0	238,324		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	242,571		50.00
51.00	05100	RECOVERY ROOM	0	34,479		51.00
53.00	05300	ANESTHESIOLOGY	0	6,527		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,019	936,527		54.00
60.00	06000	LABORATORY	-30,338	984,232		60.00
64.00	06400	INTRAVENOUS THERAPY	0	9,816		64.00
65.00	06500	RESPIRATORY THERAPY	-18,584	275,677		65.00
66.00	06600	PHYSICAL THERAPY	0	619,051		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	25,018		67.00
68.00	06800	SPEECH PATHOLOGY	0	14,857		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,475	281,632		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-3,380	668,484		73.00
76.00	03020	CARDIAC REHAB	-3,680	53,451		76.00
76.01	03021	BEHAVIORAL HEALTH	0	224,172		76.01
76.02	03023	WOUND CLINIC	0	104,875		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-15,600	19,251		90.00
91.00	09100	EMERGENCY	-462,233	1,330,129		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-853,603	11,601,886		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-11,077	785,562		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	MEDICAL OFFICE BUILDING	0	104,464		194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-864,680	12,491,912		200.00

RECLASSIFICATIONS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-6 | Date/Time Prepared: 10/29/2013 1:22 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DEPRECIATION EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT-BLDG 1	1.01	0	12,017	1.00
2.00	CAP REL COSTS-BLDG & FIXT-BLDG 2	1.02	0	80,598	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	416,181	3.00
4.00	OPERATION OF PLANT	7.00	0	828	4.00
5.00	PHYSICAL THERAPY	66.00	0	7,667	5.00
	TOTALS		0	517,291	
	B - WORKERS COMPENSATION				
1.00	EMPLOYEE BENEFITS	4.00	0	85,332	1.00
	TOTALS		0	85,332	
	C - INTEREST EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,270	1.00
	TOTALS		0	4,270	
	D - EQUIPMENT RENTAL				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	22,968	1.00
	TOTALS		0	22,968	
	E - CAFETERIA EXPENSE				
1.00	CAFETERIA	11.00	53,560	39,649	1.00
	TOTALS		53,560	39,649	
	F - OXYGEN EXPENSE				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	23,224	1.00
	TOTALS		0	23,224	
	G - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	23,518	1.00
	TOTALS		0	23,518	
	H - ADVERTISING				
1.00	OTHER A&G	5.01	0	5,697	1.00
	TOTALS		0	5,697	
	I - ADMINISTRATION				
1.00	EMPLOYEE BENEFITS	4.00	55,462	0	1.00
2.00	DATA PROCESSING	5.02	131,350	137,652	2.00
3.00	BILLING, COLLECTION, & ADMITTING	5.03	151,640	95,456	3.00
	TOTALS		338,452	233,108	
	J - CRNA				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	284,992	1.00
	TOTALS		0	284,992	
	K - PROPERTY TAX				
1.00	OTHER CAP REL COSTS	3.00	0	3,872	1.00
	TOTALS		0	3,872	
	L - DISCONTINUED SERVICE				
1.00	OTHER A&G	5.01	0	8	1.00
	TOTALS		0	8	
500.00	Grand Total: Increases		392,012	1,243,929	500.00

RECLASSIFICATIONS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-6 | Date/Time Prepared: 10/29/2013 1:22 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	517,291	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		0	517,291			
	B - WORKERS COMPENSATION						
1.00	OTHER A&G	5.01	0	85,332	0		1.00
	TOTALS		0	85,332			
	C - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	4,270	11		1.00
	TOTALS		0	4,270			
	D - EQUIPMENT RENTAL						
1.00	OTHER A&G	5.01	0	22,968	10		1.00
	TOTALS		0	22,968			
	E - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	53,560	39,649	0		1.00
	TOTALS		53,560	39,649			
	F - OXYGEN EXPENSE						
1.00	RESPIRATORY THERAPY	65.00	0	23,224	0		1.00
	TOTALS		0	23,224			
	G - PROPERTY INSURANCE						
1.00	OTHER A&G	5.01	0	23,518	12		1.00
	TOTALS		0	23,518			
	H - ADVERTISING						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,697	0		1.00
	TOTALS		0	5,697			
	I - ADMINISTRATION						
1.00	OTHER A&G	5.01	338,452	233,108	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		338,452	233,108			
	J - CRNA						
1.00	ANESTHESIOLOGY	53.00	0	284,992	0		1.00
	TOTALS		0	284,992			
	K - PROPERTY TAX						
1.00	OTHER A&G	5.01	0	3,872	0		1.00
	TOTALS		0	3,872			
	L - DISCONTINUED SERVICE						
1.00	HOME HEALTH AGENCY	101.00	0	8	0		1.00
	TOTALS		0	8			
500.00	Grand Total: Decreases		392,012	1,243,929			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part I | Date/Time Prepared: 10/29/2013 1:22 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	520,386	0	0	0	0	1.00
2.00	Land Improvements	475,384	0	0	0	0	2.00
3.00	Buildings and Fixtures	3,432,958	0	0	0	0	3.00
4.00	Building Improvements	2,422,836	45,703	0	45,703	0	4.00
5.00	Fixed Equipment	168,485	0	0	0	4,465	5.00
6.00	Movable Equipment	4,413,002	358,696	0	358,696	70,522	6.00
7.00	HIT designated Assets	0	333,261	0	333,261	0	7.00
8.00	Subtotal (sum of lines 1-7)	11,433,051	737,660	0	737,660	74,987	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	11,433,051	737,660	0	737,660	74,987	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	520,386	0	1.00
2.00	Land Improvements	475,384	0	2.00
3.00	Buildings and Fixtures	3,432,958	0	3.00
4.00	Building Improvements	2,468,539	0	4.00
5.00	Fixed Equipment	164,020	0	5.00
6.00	Movable Equipment	4,701,176	0	6.00
7.00	HIT designated Assets	333,261	0	7.00
8.00	Subtotal (sum of lines 1-7)	12,095,724	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	12,095,724	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part II | Date/Time Prepared: 10/29/2013 1:22 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	545,398	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	545,398	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	545,398		1.00
1.01	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	0		1.01
1.02	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	0		1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	545,398		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part III | Date/Time Prepared: 10/29/2013 1:22 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	995,770	0	995,770	0.083836	1,972	1.00
1.01	CAP REL COSTS-BLDG & FIXT- BLDG 1	930,645	0	930,645	0.078353	1,843	1.01
1.02	CAP REL COSTS-BLDG & FIXT- BLDG 2	4,970,852	0	4,970,852	0.418504	9,842	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	5,198,457	218,063	4,980,394	0.419307	9,861	2.00
3.00	Total (sum of lines 1-2)	12,095,724	218,063	11,877,661	1.000000	23,518	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1,972	28,107	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	0	1,843	12,017	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	0	9,842	80,598	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	9,861	327,293	22,968	2.00
3.00	Total (sum of lines 1-2)	0	0	23,518	448,015	22,968	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,972	0	0	30,079	1.00
1.01	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	1,843	0	0	13,860	1.01
1.02	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	9,842	0	0	90,440	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	2,352	9,861	0	0	362,474	2.00
3.00	Total (sum of lines 1-2)	2,352	23,518	0	0	496,853	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8 | Date/Time Prepared: 10/29/2013 1:22 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT- BLDG 1 (chapter 2)		0	CAP REL COSTS-BLDG & FIXT-BLDG 1	1.01	0	1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT- BLDG 2 (chapter 2)		0	CAP REL COSTS-BLDG & FIXT-BLDG 2	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-1,918	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-11,077	PHYSICIANS' PRIVATE OFFICES	192.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-27,537	OTHER A&G	5.01	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-15,600	CLINIC	90.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-7,861	OTHER A&G	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,677	OTHER A&G	5.01	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-511,155			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-32,967	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-1,475	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-3,380	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,603	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT- BLDG 1		0	CAP REL COSTS-BLDG & FIXT-BLDG 1	1.01	0	26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT- BLDG 2		0	CAP REL COSTS-BLDG & FIXT-BLDG 2	1.02	0	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8 | Date/Time Prepared: 10/29/2013 1:22 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-88,888	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	IHA LOBBYING FEES	A	-6,167	OTHER A&G	5.01	0	33.00
33.01	TAXES	A	-3,872	OTHER CAP REL COSTS	3.00	13	33.01
33.02	MEDICAID PROVIDER TAX	A	-75,123	OTHER A&G	5.01	0	33.02
33.03	TRANSCRIPTION SERVICE	B	-2,900	MEDICAL RECORDS & LIBRARY	16.00	0	33.03
33.04	MISCELLANEOUS OPERATING REVENUE	B	-3,626	OTHER A&G	5.01	0	33.04
33.05	X-RAY FILM COPYING	B	-1,019	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	INSERVICE EDUCATION	B	-1,041	NURSING ADMINISTRATION	13.00	0	33.06
33.07	CARDIAC REHAB	B	-3,680	CARDIAC REHAB	76.00	0	33.07
33.08	DIABETIC CONSULTATION	B	-630	DIETARY	10.00	0	33.08
33.09	PUBLIC RELATIONS SALARIES	A	-27,011	OTHER A&G	5.01	0	33.09
33.10	PUBLIC RELATIONS OTHER	A	-11,999	OTHER A&G	5.01	0	33.10
33.11	PUBLIC RELATIONS BENEFITS	A	-6,427	EMPLOYEE BENEFITS	4.00	0	33.11
33.12	PUBLIC RELATIONS OTHER	A	-6,350	BILLING, COLLECTION, & ADMITTING	5.03	0	33.12
33.13	PHYSICIAN ADVERTISING EXPENSE	A	-5,697	OTHER A&G	5.01	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-864,680				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-2 | Date/Time Prepared: 10/29/2013 1:22 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	57,906	30,338	27,568	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	18,584	18,584	0	0	0	2.00
3.00	91.00	EMERGENCY	1,346,048	462,233	883,815	0	0	3.00
4.00	76.01	BEHAVIORAL HEALTH	26,500	0	26,500	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,449,038	511,155	937,883		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	76.01	BEHAVIORAL HEALTH	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	30,338		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	18,584		2.00
3.00	91.00	EMERGENCY	0	0	0	462,233		3.00
4.00	76.01	BEHAVIORAL HEALTH	0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	511,155		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 10/29/2013 1:22 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					255	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	1,802.00	1,491.00	5,099.00	683.50	0.00	9.00
10.00	AHSEA (see instructions)	100.40	74.37	55.78	37.19	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)	37.19	37.19	27.89			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)					180,921	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					110,886	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					284,422	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					576,229	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					25,419	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)					601,648	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					601,648	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					9,483	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					9,483	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,403	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					10,886	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)					10,886	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 10/29/2013 1:22 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	74.37	55.78	37.19	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)	601,648		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	10,886		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)	2,498		62.00
63.00	Total allowance (sum of lines 57-62)	615,032		63.00
64.00	Total cost of outside supplier services (from your records)	566,300		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	9,483		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,403		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	10,886		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,403		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	1,403		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 10/29/2013 1:22 pm

		Occupational 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)	197	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)	7	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	5.50	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	365.75	11.75	0.00	0.00	9.00
10.00	AHSEA (see instructions)	95.18	70.50	52.88	35.25	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)	35.25	35.25	26.44			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)	25,785	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	621	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	26,406	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)	26,406	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)	69.95	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	54,561	22.00
23.00	Total salary equivalency (see instructions)	54,561	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)	6,944	24.00
25.00	Assistants (line 4 times column 3, line 11)	185	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	7,129	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,122	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	8,251	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)	8,251	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 10/29/2013 1:22 pm

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	70.50	52.88	35.25	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)	54,561	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	8,251	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)	62,812	63.00
64.00	Total cost of outside supplier services (from your records)	25,018	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	7,129	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,122	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	8,251	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,122	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,122	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 10/29/2013 1:22 pm

Speech Pathology | 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)					90	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	221.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	91.45	67.74	50.81	33.87	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.87	33.87	25.41			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)					14,971	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)					14,971	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)					14,971	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)					67.74	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					52,837	22.00
23.00	Total salary equivalency (see instructions)					52,837	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)					3,048	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)					3,048	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)					495	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					3,543	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)					3,543	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 10/29/2013 1:22 pm

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	67.74	50.81	33.87	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)	52,837	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	3,543	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)	56,380	63.00
64.00	Total cost of outside supplier services (from your records)	14,857	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	3,048	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	495	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	3,543	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	495	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	495	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 10/29/2013 1:22 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT- BLDG 1	BLDG & FIXT- BLDG 2	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	30,079	30,079				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1	13,860	0	13,860			1.01
1.02	00103	CAP REL COSTS-BLDG & FIXT- BLDG 2	90,440	0	0	90,440		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	362,474				362,474	2.00
4.00	00400	EMPLOYEE BENEFITS	1,366,687	0	0	0	0	4.00
5.01	00510	OTHER A&G	775,785	3,355	3,374	3,424	40,728	5.01
5.02	00520	DATA PROCESSING	269,002	0	0	0	0	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	240,746	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	503,977	7,003	4,038	18,096	85,007	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	32,037	606	779	0	7,353	8.00
9.00	00900	HOUSEKEEPING	175,923	541	255	1,607	6,566	9.00
10.00	01000	DIETARY	117,369	770	0	3,608	9,345	10.00
11.00	01100	CAFETERIA	60,242	543	0	2,544	6,589	11.00
13.00	01300	NURSING ADMINISTRATION	249,074	300	0	1,407	3,645	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	187,542	563	87	2,319	6,831	16.00
17.00	01700	SOCIAL SERVICE	57,253	121	0	566	1,465	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	284,992	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	715,331	4,433	0	20,777	53,809	30.00
31.00	03100	INTENSIVE CARE UNIT	238,324	538	0	2,521	6,529	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	242,571	1,563	0	7,324	18,970	50.00
51.00	05100	RECOVERY ROOM	34,479	359	0	1,683	4,359	51.00
53.00	05300	ANESTHESIOLOGY	6,527	41	0	194	504	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	936,527	2,130	0	9,985	25,861	54.00
60.00	06000	LABORATORY	984,232	792	1,018	0	9,615	60.00
64.00	06400	INTRAVENOUS THERAPY	9,816	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	275,677	548	0	2,570	6,657	65.00
66.00	06600	PHYSICAL THERAPY	619,051	0	0	0	14,652	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,018	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,857	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	281,632	688	884	0	8,352	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	668,484	287	0	1,344	3,480	73.00
76.00	03020	CARDIAC REHAB	53,451	754	0	3,534	9,153	76.00
76.01	03021	BEHAVIORAL HEALTH	224,172	1,260	1,619	0	15,293	76.01
76.02	03023	WOUND CLINIC	104,875	81	105	0	989	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	19,251	511	0	2,397	6,209	90.00
91.00	09100	EMERGENCY	1,330,129	866	0	4,059	10,513	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,601,886	28,653	12,159	89,959	362,474	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	103	0	481	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	785,562	1,293	1,662	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MEDICAL OFFICE BUILDING	104,464	30	39	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,491,912	30,079	13,860	90,440	362,474	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 10/29/2013 1:22 pm

		Cost Center Description	EMPLOYEE BENEFITS	Subtotal	OTHER A&G	Subtotal	DATA PROCESSING	
			4.00	4A	5.01	5A.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00103	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	1,366,687					4.00
5.01	00510	OTHER A&G	116,593	943,259	943,259			5.01
5.02	00520	DATA PROCESSING	32,908	301,910	24,659	326,569	326,569	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	37,992	278,738	22,766	301,504	8,094	5.03
7.00	00700	OPERATION OF PLANT	40,880	659,001	53,825	712,826	19,135	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,810	46,585	3,805	50,390	1,353	8.00
9.00	00900	HOUSEKEEPING	40,097	224,989	18,376	243,365	6,533	9.00
10.00	01000	DIETARY	16,988	148,080	12,095	160,175	4,300	10.00
11.00	01100	CAFETERIA	13,419	83,337	6,807	90,144	2,420	11.00
13.00	01300	NURSING ADMINISTRATION	58,519	312,945	25,560	338,505	9,087	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	40,500	237,842	19,426	257,268	6,906	16.00
17.00	01700	SOCIAL SERVICE	14,344	73,749	6,024	79,773	2,141	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	284,992	23,277	308,269	8,275	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	168,528	962,878	78,645	1,041,523	27,959	30.00
31.00	03100	INTENSIVE CARE UNIT	59,709	307,621	25,126	332,747	8,932	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	47,503	317,931	25,968	343,899	9,232	50.00
51.00	05100	RECOVERY ROOM	8,638	49,518	4,044	53,562	1,438	51.00
53.00	05300	ANESTHESIOLOGY	0	7,266	593	7,859	211	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	104,184	1,078,687	88,104	1,166,791	31,321	54.00
60.00	06000	LABORATORY	125,687	1,121,344	91,588	1,212,932	32,560	60.00
64.00	06400	INTRAVENOUS THERAPY	0	9,816	802	10,618	285	64.00
65.00	06500	RESPIRATORY THERAPY	42,250	327,702	26,766	354,468	9,515	65.00
66.00	06600	PHYSICAL THERAPY	8,281	641,984	52,435	694,419	18,641	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	25,018	2,043	27,061	726	67.00
68.00	06800	SPEECH PATHOLOGY	0	14,857	1,213	16,070	431	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,233	314,789	25,711	340,500	9,140	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,210	712,805	58,220	771,025	20,697	73.00
76.00	03020	CARDIAC REHAB	14,152	81,044	6,619	87,663	2,353	76.00
76.01	03021	BEHAVIORAL HEALTH	29,686	272,030	22,219	294,249	7,899	76.01
76.02	03023	WOUND CLINIC	0	106,050	8,662	114,712	3,079	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,333	34,701	2,834	37,535	1,008	90.00
91.00	09100	EMERGENCY	103,195	1,448,762	118,332	1,567,094	42,071	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,198,639	11,430,230	856,544	11,343,515	295,742	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	584	48	632	17	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	168,048	956,565	78,129	1,034,694	27,775	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MEDICAL OFFICE BUILDING	0	104,533	8,538	113,071	3,035	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,366,687	12,491,912	943,259	12,491,912	326,569	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 10/29/2013 1:22 pm

		Cost Center Description	BILLING, COLLECTION, & ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.03	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00103	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	OTHER A&G						5.01
5.02	00520	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	309,598					5.03
7.00	00700	OPERATION OF PLANT	0	731,961				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,187	72,930			8.00
9.00	00900	HOUSEKEEPING	0	18,918	0	268,816		9.00
10.00	01000	DIETARY	0	26,926	0	11,212	202,613	10.00
11.00	01100	CAFETERIA	0	18,984	0	7,905	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,501	0	4,373	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,683	0	8,196	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,222	0	1,758	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,103	155,040	64,469	64,555	179,106	30.00
31.00	03100	INTENSIVE CARE UNIT	2,595	18,813	8,461	7,833	23,507	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,355	54,657	0	22,758	0	50.00
51.00	05100	RECOVERY ROOM	1,360	12,559	0	5,230	0	51.00
53.00	05300	ANESTHESIOLOGY	5,730	1,451	0	604	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	84,783	74,511	0	31,026	0	54.00
60.00	06000	LABORATORY	82,656	27,704	0	11,536	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,902	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	20,204	19,182	0	7,987	0	65.00
66.00	06600	PHYSICAL THERAPY	30,448	42,216	0	17,578	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	777	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	329	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,126	24,063	0	10,020	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,319	10,026	0	4,175	0	73.00
76.00	03020	CARDIAC REHAB	1,056	26,372	0	10,981	0	76.00
76.01	03021	BEHAVIORAL HEALTH	7,735	44,063	0	18,347	0	76.01
76.02	03023	WOUND CLINIC	1,957	2,850	0	1,187	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	471	17,889	0	7,449	0	90.00
91.00	09100	EMERGENCY	17,875	30,290	0	12,612	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	301,781	682,107	72,930	267,322	202,613	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,588	0	1,494	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,817	45,211	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MEDICAL OFFICE BUILDING	0	1,055	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	309,598	731,961	72,930	268,816	202,613	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 10/29/2013 1:22 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00103	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	OTHER A&G						5.01
5.02	00520	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	119,453					11.00
13.00	01300	NURSING ADMINISTRATION	7,820	370,286				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,412	0	297,465			16.00
17.00	01700	SOCIAL SERVICE	1,917	0	0	89,811		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	316,544	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,518	158,424	8,746	79,391	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7,979	56,128	2,493	10,420	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,348	44,654	8,989	0	0	50.00
51.00	05100	RECOVERY ROOM	1,154	8,120	1,306	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	5,505	0	316,544	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,921	0	81,462	0	0	54.00
60.00	06000	LABORATORY	16,795	0	79,417	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	1,827	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,646	0	19,412	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,106	0	29,255	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	747	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	316	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,105	0	6,846	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,239	0	15,680	0	0	73.00
76.00	03020	CARDIAC REHAB	1,891	0	1,015	0	0	76.00
76.01	03021	BEHAVIORAL HEALTH	3,967	0	7,431	0	0	76.01
76.02	03023	WOUND CLINIC	0	0	1,880	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	846	5,953	452	0	0	90.00
91.00	09100	EMERGENCY	13,789	97,007	17,175	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	119,453	370,286	289,954	89,811	316,544	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	7,511	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	119,453	370,286	297,465	89,811	316,544	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 10/29/2013 1:22 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1					1.01
1.02	00103	CAP REL COSTS-BLDG & FIXT- BLDG 2					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	OTHER A&G					5.01
5.02	00520	DATA PROCESSING					5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,810,834	0	1,810,834		30.00
31.00	03100	INTENSIVE CARE UNIT	479,908	0	479,908		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	499,892	0	499,892		50.00
51.00	05100	RECOVERY ROOM	84,729	0	84,729		51.00
53.00	05300	ANESTHESIOLOGY	337,904	0	337,904		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,483,815	0	1,483,815		54.00
60.00	06000	LABORATORY	1,463,600	0	1,463,600		60.00
64.00	06400	INTRAVENOUS THERAPY	14,632	0	14,632		64.00
65.00	06500	RESPIRATORY THERAPY	436,414	0	436,414		65.00
66.00	06600	PHYSICAL THERAPY	833,663	0	833,663		66.00
67.00	06700	OCCUPATIONAL THERAPY	29,311	0	29,311		67.00
68.00	06800	SPEECH PATHOLOGY	17,146	0	17,146		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	400,800	0	400,800		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	843,161	0	843,161		73.00
76.00	03020	CARDIAC REHAB	131,331	0	131,331		76.00
76.01	03021	BEHAVIORAL HEALTH	383,691	0	383,691		76.01
76.02	03023	WOUND CLINIC	125,665	0	125,665		76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	71,603	0	71,603		90.00
91.00	09100	EMERGENCY	1,797,913	0	1,797,913		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,246,012	0	11,246,012		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,731	0	5,731		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,123,008	0	1,123,008		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	MEDICAL OFFICE BUILDING	117,161	0	117,161		194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0		194.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	12,491,912	0	12,491,912		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 10/29/2013 1:22 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	BLDG & FIXT- BLDG 1	BLDG & FIXT- BLDG 2	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00103	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.01	00510	OTHER A&G	0	3,355	3,374	3,424	40,728	5.01
5.02	00520	DATA PROCESSING	0	0	0	0	0	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	828	7,003	4,038	18,096	85,007	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	606	779	0	7,353	8.00
9.00	00900	HOUSEKEEPING	0	541	255	1,607	6,566	9.00
10.00	01000	DIETARY	0	770	0	3,608	9,345	10.00
11.00	01100	CAFETERIA	0	543	0	2,544	6,589	11.00
13.00	01300	NURSING ADMINISTRATION	0	300	0	1,407	3,645	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	563	87	2,319	6,831	16.00
17.00	01700	SOCIAL SERVICE	0	121	0	566	1,465	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,433	0	20,777	53,809	30.00
31.00	03100	INTENSIVE CARE UNIT	0	538	0	2,521	6,529	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,563	0	7,324	18,970	50.00
51.00	05100	RECOVERY ROOM	0	359	0	1,683	4,359	51.00
53.00	05300	ANESTHESIOLOGY	0	41	0	194	504	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,130	0	9,985	25,861	54.00
60.00	06000	LABORATORY	0	792	1,018	0	9,615	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	548	0	2,570	6,657	65.00
66.00	06600	PHYSICAL THERAPY	7,667	0	0	0	14,652	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	688	884	0	8,352	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	287	0	1,344	3,480	73.00
76.00	03020	CARDIAC REHAB	0	754	0	3,534	9,153	76.00
76.01	03021	BEHAVIORAL HEALTH	0	1,260	1,619	0	15,293	76.01
76.02	03023	WOUND CLINIC	0	81	105	0	989	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	511	0	2,397	6,209	90.00
91.00	09100	EMERGENCY	0	866	0	4,059	10,513	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,495	28,653	12,159	89,959	362,474	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	103	0	481	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	72,290	1,293	1,662	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MEDICAL OFFICE BUILDING	0	30	39	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	80,785	30,079	13,860	90,440	362,474	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 10/29/2013 1:22 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS	OTHER A&G	DATA PROCESSING	BILLING, COLLECTION, & ADMITTING	
			2A	4.00	5.01	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00103	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	0				4.00
5.01	00510	OTHER A&G	50,881	0	50,881			5.01
5.02	00520	DATA PROCESSING	0	0	1,330	1,330		5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	0	1,228	33	1,261	5.03
7.00	00700	OPERATION OF PLANT	114,972	0	2,904	78	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,738	0	205	5	0	8.00
9.00	00900	HOUSEKEEPING	8,969	0	991	27	0	9.00
10.00	01000	DIETARY	13,723	0	652	17	0	10.00
11.00	01100	CAFETERIA	9,676	0	367	10	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,352	0	1,379	37	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,800	0	1,048	28	0	16.00
17.00	01700	SOCIAL SERVICE	2,152	0	325	9	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	1,256	34	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	79,019	0	4,242	114	37	30.00
31.00	03100	INTENSIVE CARE UNIT	9,588	0	1,355	36	11	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,857	0	1,401	37	38	50.00
51.00	05100	RECOVERY ROOM	6,401	0	218	6	6	51.00
53.00	05300	ANESTHESIOLOGY	739	0	32	1	23	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,976	0	4,753	127	344	54.00
60.00	06000	LABORATORY	11,425	0	4,941	132	337	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	43	1	8	64.00
65.00	06500	RESPIRATORY THERAPY	9,775	0	1,444	39	82	65.00
66.00	06600	PHYSICAL THERAPY	22,319	0	2,829	76	124	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	110	3	3	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	65	2	1	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,924	0	1,387	37	29	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,111	0	3,141	84	67	73.00
76.00	03020	CARDIAC REHAB	13,441	0	357	10	4	76.00
76.01	03021	BEHAVIORAL HEALTH	18,172	0	1,199	32	32	76.01
76.02	03023	WOUND CLINIC	1,175	0	467	13	8	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,117	0	153	4	2	90.00
91.00	09100	EMERGENCY	15,438	0	6,380	173	73	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	501,740	0	46,202	1,205	1,229	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	584	0	3	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	75,245	0	4,215	113	32	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MEDICAL OFFICE BUILDING	69	0	461	12	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	577,638	0	50,881	1,330	1,261	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 10/29/2013 1:22 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00103	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	OTHER A&G						5.01
5.02	00520	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT	117,954					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,414	12,362				8.00
9.00	00900	HOUSEKEEPING	3,049	0	13,036			9.00
10.00	01000	DIETARY	4,339	0	544	19,275		10.00
11.00	01100	CAFETERIA	3,059	0	383	0	13,495	11.00
13.00	01300	NURSING ADMINISTRATION	1,692	0	212	0	883	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,172	0	397	0	611	16.00
17.00	01700	SOCIAL SERVICE	680	0	85	0	217	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,984	10,928	3,131	17,039	2,544	30.00
31.00	03100	INTENSIVE CARE UNIT	3,032	1,434	380	2,236	901	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,808	0	1,104	0	717	50.00
51.00	05100	RECOVERY ROOM	2,024	0	254	0	130	51.00
53.00	05300	ANESTHESIOLOGY	234	0	29	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,007	0	1,505	0	1,573	54.00
60.00	06000	LABORATORY	4,464	0	559	0	1,897	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,091	0	387	0	638	65.00
66.00	06600	PHYSICAL THERAPY	6,803	0	852	0	125	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,878	0	486	0	351	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,616	0	202	0	592	73.00
76.00	03020	CARDIAC REHAB	4,250	0	533	0	214	76.00
76.01	03021	BEHAVIORAL HEALTH	7,101	0	890	0	448	76.01
76.02	03023	WOUND CLINIC	459	0	58	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,883	0	361	0	96	90.00
91.00	09100	EMERGENCY	4,881	0	612	0	1,558	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	109,920	12,362	12,964	19,275	13,495	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	578	0	72	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,286	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MEDICAL OFFICE BUILDING	170	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	117,954	12,362	13,036	19,275	13,495	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 10/29/2013 1:22 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			13.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00103	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	OTHER A&G						5.01
5.02	00520	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	9,555					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,056				16.00
17.00	01700	SOCIAL SERVICE	0	0	3,468			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	1,290		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,088	443	3,066		149,635	30.00
31.00	03100	INTENSIVE CARE UNIT	1,448	126	402		20,949	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,152	455	0		41,569	50.00
51.00	05100	RECOVERY ROOM	210	66	0		9,315	51.00
53.00	05300	ANESTHESIOLOGY	0	279	0		1,337	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,117	0		62,402	54.00
60.00	06000	LABORATORY	0	4,022	0		27,777	60.00
64.00	06400	INTRAVENOUS THERAPY	0	93	0		145	64.00
65.00	06500	RESPIRATORY THERAPY	0	983	0		16,439	65.00
66.00	06600	PHYSICAL THERAPY	0	1,482	0		34,610	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	38	0		154	67.00
68.00	06800	SPEECH PATHOLOGY	0	16	0		84	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	347	0		16,439	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	794	0		11,607	73.00
76.00	03020	CARDIAC REHAB	0	51	0		18,860	76.00
76.01	03021	BEHAVIORAL HEALTH	0	376	0		28,250	76.01
76.02	03023	WOUND CLINIC	0	95	0		2,275	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	154	23	0		12,793	90.00
91.00	09100	EMERGENCY	2,503	870	0		32,488	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,555	14,676	3,468	0	487,128	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		1,237	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	380	0		87,271	192.00
193.00	19300	NONPAID WORKERS	0	0	0		0	193.00
194.00	07950	MEDICAL OFFICE BUILDING	0	0	0		712	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0		0	194.01
200.00		Cross Foot Adjustments				1,290	1,290	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	9,555	15,056	3,468	1,290	577,638	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 10/29/2013 1:22 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1				1.01
1.02	00103	CAP REL COSTS-BLDG & FIXT- BLDG 2				1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.01	00510	OTHER A&G				5.01
5.02	00520	DATA PROCESSING				5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING				5.03
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	149,635		30.00
31.00	03100	INTENSIVE CARE UNIT	0	20,949		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	41,569		50.00
51.00	05100	RECOVERY ROOM	0	9,315		51.00
53.00	05300	ANESTHESIOLOGY	0	1,337		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	62,402		54.00
60.00	06000	LABORATORY	0	27,777		60.00
64.00	06400	INTRAVENOUS THERAPY	0	145		64.00
65.00	06500	RESPIRATORY THERAPY	0	16,439		65.00
66.00	06600	PHYSICAL THERAPY	0	34,610		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	154		67.00
68.00	06800	SPEECH PATHOLOGY	0	84		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,439		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,607		73.00
76.00	03020	CARDIAC REHAB	0	18,860		76.00
76.01	03021	BEHAVIORAL HEALTH	0	28,250		76.01
76.02	03023	WOUND CLINIC	0	2,275		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	12,793		90.00
91.00	09100	EMERGENCY	0	32,488		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	487,128		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,237		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	87,271		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	MEDICAL OFFICE BUILDING	0	712		194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0		194.01
200.00		Cross Foot Adjustments	0	1,290		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	577,638		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 10/29/2013 1:22 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-BLDG 1 (SQUARE FEET)	BLDG & FIXT-BLDG 2 (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	
			1.00	1.01	1.02	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	79,744					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	28,586				1.01
1.02	00103	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	0	51,158			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				79,165		2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0	0	5,455,011	4.00
5.01	00510	OTHER A&G	8,895	6,958	1,937	8,895	465,371	5.01
5.02	00520	DATA PROCESSING	0	0	0	0	131,350	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	0	0	0	151,640	5.03
7.00	00700	OPERATION OF PLANT	18,566	8,330	10,236	18,566	163,167	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,606	1,606	0	1,606	23,192	8.00
9.00	00900	HOUSEKEEPING	1,434	525	909	1,434	160,044	9.00
10.00	01000	DIETARY	2,041	0	2,041	2,041	67,805	10.00
11.00	01100	CAFETERIA	1,439	0	1,439	1,439	53,560	11.00
13.00	01300	NURSING ADMINISTRATION	796	0	796	796	233,572	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,492	180	1,312	1,492	161,652	16.00
17.00	01700	SOCIAL SERVICE	320	0	320	320	57,253	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,752	0	11,752	11,752	672,670	30.00
31.00	03100	INTENSIVE CARE UNIT	1,426	0	1,426	1,426	238,324	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,143	0	4,143	4,143	189,605	50.00
51.00	05100	RECOVERY ROOM	952	0	952	952	34,479	51.00
53.00	05300	ANESTHESIOLOGY	110	0	110	110	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,648	0	5,648	5,648	415,840	54.00
60.00	06000	LABORATORY	2,100	2,100	0	2,100	501,667	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,454	0	1,454	1,454	168,638	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,200	33,051	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,824	1,824	0	1,824	92,733	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	760	0	760	760	156,503	73.00
76.00	03020	CARDIAC REHAB	1,999	0	1,999	1,999	56,485	76.00
76.01	03021	BEHAVIORAL HEALTH	3,340	3,340	0	3,340	118,488	76.01
76.02	03023	WOUND CLINIC	216	216	0	216	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,356	0	1,356	1,356	25,277	90.00
91.00	09100	EMERGENCY	2,296	0	2,296	2,296	411,895	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	75,965	25,079	50,886	79,165	4,784,261	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	272	0	272	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,427	3,427	0	0	670,750	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MEDICAL OFFICE BUILDING	80	80	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	30,079	13,860	90,440	362,474	1,366,687	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.377195	0.484853	1.767856	4.578715	0.250538	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 10/29/2013 1:22 pm

		Cost Center Description	Reconciliation	OTHER A&G (ACCUM. COST)	Reconciliation	DATA PROCESSING (ACCUM. COST)	BILLING, COLLECTION, & ADMITTING (GROSS CHARGES)	
			5A.01	5.01	5A.02	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00103	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	OTHER A&G	-943,259	11,548,653				5.01
5.02	00520	DATA PROCESSING	0	301,910	-326,569	12,165,343		5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	278,738	0	301,504	22,551,861	5.03
7.00	00700	OPERATION OF PLANT	0	659,001	0	712,826	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	46,585	0	50,390	0	8.00
9.00	00900	HOUSEKEEPING	0	224,989	0	243,365	0	9.00
10.00	01000	DIETARY	0	148,080	0	160,175	0	10.00
11.00	01100	CAFETERIA	0	83,337	0	90,144	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	312,945	0	338,505	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	237,842	0	257,268	0	16.00
17.00	01700	SOCIAL SERVICE	0	73,749	0	79,773	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	284,992	0	308,269	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	962,878	0	1,041,523	663,066	30.00
31.00	03100	INTENSIVE CARE UNIT	0	307,621	0	332,747	189,009	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	317,931	0	343,899	681,478	50.00
51.00	05100	RECOVERY ROOM	0	49,518	0	53,562	99,041	51.00
53.00	05300	ANESTHESIOLOGY	0	7,266	0	7,859	417,384	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,078,687	0	1,166,791	6,175,510	54.00
60.00	06000	LABORATORY	0	1,121,344	0	1,212,932	6,021,003	60.00
64.00	06400	INTRAVENOUS THERAPY	0	9,816	0	10,618	138,536	64.00
65.00	06500	RESPIRATORY THERAPY	0	327,702	0	354,468	1,471,745	65.00
66.00	06600	PHYSICAL THERAPY	0	641,984	0	694,419	2,217,937	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	25,018	0	27,061	56,616	67.00
68.00	06800	SPEECH PATHOLOGY	0	14,857	0	16,070	23,931	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	314,789	0	340,500	519,066	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	712,805	0	771,025	1,188,769	73.00
76.00	03020	CARDIAC REHAB	0	81,044	0	87,663	76,922	76.00
76.01	03021	BEHAVIORAL HEALTH	0	272,030	0	294,249	563,416	76.01
76.02	03023	WOUND CLINIC	0	106,050	0	114,712	142,568	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	34,701	0	37,535	34,304	90.00
91.00	09100	EMERGENCY	0	1,448,762	0	1,567,094	1,302,108	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-943,259	10,486,971	-326,569	11,016,946	21,982,409	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	584	0	632	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	956,565	0	1,034,694	569,452	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MEDICAL OFFICE BUILDING	0	104,533	0	113,071	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		943,259		326,569	309,598	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.081677		0.026844	0.013728	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		50,881		1,330	1,261	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.004406		0.000109	0.000056	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 10/29/2013 1:22 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00103	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	OTHER A&G						5.01
5.02	00520	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT	55,483					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,606	1,155				8.00
9.00	00900	HOUSEKEEPING	1,434	0	48,936			9.00
10.00	01000	DIETARY	2,041	0	2,041	1,155		10.00
11.00	01100	CAFETERIA	1,439	0	1,439	0	3,568,132	11.00
13.00	01300	NURSING ADMINISTRATION	796	0	796	0	233,572	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,492	0	1,492	0	161,652	16.00
17.00	01700	SOCIAL SERVICE	320	0	320	0	57,253	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,752	1,021	11,752	1,021	672,670	30.00
31.00	03100	INTENSIVE CARE UNIT	1,426	134	1,426	134	238,324	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,143	0	4,143	0	189,605	50.00
51.00	05100	RECOVERY ROOM	952	0	952	0	34,479	51.00
53.00	05300	ANESTHESIOLOGY	110	0	110	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,648	0	5,648	0	415,840	54.00
60.00	06000	LABORATORY	2,100	0	2,100	0	501,667	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,454	0	1,454	0	168,638	65.00
66.00	06600	PHYSICAL THERAPY	3,200	0	3,200	0	33,051	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,824	0	1,824	0	92,733	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	760	0	760	0	156,503	73.00
76.00	03020	CARDIAC REHAB	1,999	0	1,999	0	56,485	76.00
76.01	03021	BEHAVIORAL HEALTH	3,340	0	3,340	0	118,488	76.01
76.02	03023	WOUND CLINIC	216	0	216	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,356	0	1,356	0	25,277	90.00
91.00	09100	EMERGENCY	2,296	0	2,296	0	411,895	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	51,704	1,155	48,664	1,155	3,568,132	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	272	0	272	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,427	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MEDICAL OFFICE BUILDING	80	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	731,961	72,930	268,816	202,613	119,453	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.192527	63.142857	5.493216	175.422511	0.033478	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	117,954	12,362	13,036	19,275	13,495	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.125948	10.703030	0.266389	16.688312	0.003782	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 10/29/2013 1:22 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			13.00	16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00103	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	OTHER A&G						5.01
5.02	00520	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,572,250					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,551,861				16.00
17.00	01700	SOCIAL SERVICE	0	0	1,155			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	672,670	663,066	1,021			30.00
31.00	03100	INTENSIVE CARE UNIT	238,324	189,009	134			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	189,605	681,478	0	0		50.00
51.00	05100	RECOVERY ROOM	34,479	99,041	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	417,384	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,175,510	0	0		54.00
60.00	06000	LABORATORY	0	6,021,003	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	138,536	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,471,745	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,217,937	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	56,616	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	23,931	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	519,066	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,188,769	0	0		73.00
76.00	03020	CARDIAC REHAB	0	76,922	0	0		76.00
76.01	03021	BEHAVIORAL HEALTH	0	563,416	0	0		76.01
76.02	03023	WOUND CLINIC	0	142,568	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	25,277	34,304	0	0		90.00
91.00	09100	EMERGENCY	411,895	1,302,108	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,572,250	21,982,409	1,155	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	569,452	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	MEDICAL OFFICE BUILDING	0	0	0	0		194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0		194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	370,286	297,465	89,811	316,544		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.235513	0.013190	77.758442	3,165.440000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,555	15,056	3,468	1,290		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006077	0.000668	3.002597	12.900000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 10/29/2013 1:22 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,810,834		1,810,834	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	479,908		479,908	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	499,892		499,892	0	0	50.00
51.00	05100	RECOVERY ROOM	84,729		84,729	0	0	51.00
53.00	05300	ANESTHESIOLOGY	337,904		337,904	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,483,815		1,483,815	0	0	54.00
60.00	06000	LABORATORY	1,463,600		1,463,600	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	14,632		14,632	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	436,414	0	436,414	0	0	65.00
66.00	06600	PHYSICAL THERAPY	833,663	0	833,663	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,311	0	29,311	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	17,146	0	17,146	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	400,800		400,800	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	843,161		843,161	0	0	73.00
76.00	03020	CARDIAC REHAB	131,331		131,331	0	0	76.00
76.01	03021	BEHAVIORAL HEALTH	383,691		383,691	0	0	76.01
76.02	03023	WOUND CLINIC	125,665		125,665	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	71,603		71,603	0	0	90.00
91.00	09100	EMERGENCY	1,797,913		1,797,913	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	261,555		261,555		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,507,567	0	11,507,567	0	0	200.00
201.00		Less Observation Beds	261,555		261,555		0	201.00
202.00		Total (see instructions)	11,246,012	0	11,246,012	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 10/29/2013 1:22 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	475,420		475,420			30.00
31.00	03100	INTENSIVE CARE UNIT	189,009		189,009			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	41,770	639,708	681,478	0.733541	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,880	95,161	99,041	0.855494	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	28,050	389,334	417,384	0.809576	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	128,645	6,046,865	6,175,510	0.240274	0.000000	54.00
60.00	06000	LABORATORY	272,140	5,748,863	6,021,003	0.243082	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	56,884	81,652	138,536	0.105619	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	254,380	1,217,365	1,471,745	0.296528	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	141,897	2,076,040	2,217,937	0.375873	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,965	14,651	56,616	0.517716	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	3,966	19,965	23,931	0.716477	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	114,385	404,681	519,066	0.772156	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	167,416	1,021,353	1,188,769	0.709272	0.000000	73.00
76.00	03020	CARDIAC REHAB	1,436	75,486	76,922	1.707327	0.000000	76.00
76.01	03021	BEHAVIORAL HEALTH	0	563,416	563,416	0.681008	0.000000	76.01
76.02	03023	WOUND CLINIC	0	142,568	142,568	0.881439	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	34,304	34,304	2.087308	0.000000	90.00
91.00	09100	EMERGENCY	6,135	1,295,973	1,302,108	1.380771	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,160	184,486	187,646	1.393875	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	1,930,538	20,051,871	21,982,409			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,930,538	20,051,871	21,982,409			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 10/29/2013 1:22 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	CARDIAC REHAB	0.000000	76.00
76.01	03021	BEHAVIORAL HEALTH	0.000000	76.01
76.02	03023	WOUND CLINIC	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part II Date/Time Prepared: 10/29/2013 1:22 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	41,569	681,478	0.060998	21,775	1,328	50.00
51.00	05100	RECOVERY ROOM	9,315	99,041	0.094052	2,160	203	51.00
53.00	05300	ANESTHESIOLOGY	1,337	417,384	0.003203	13,464	43	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,402	6,175,510	0.010105	98,515	995	54.00
60.00	06000	LABORATORY	27,777	6,021,003	0.004613	179,451	828	60.00
64.00	06400	INTRAVENOUS THERAPY	145	138,536	0.001047	33,776	35	64.00
65.00	06500	RESPIRATORY THERAPY	16,439	1,471,745	0.011170	150,580	1,682	65.00
66.00	06600	PHYSICAL THERAPY	34,610	2,217,937	0.015605	22,836	356	66.00
67.00	06700	OCCUPATIONAL THERAPY	154	56,616	0.002720	5,505	15	67.00
68.00	06800	SPEECH PATHOLOGY	84	23,931	0.003510	766	3	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,439	519,066	0.031670	65,642	2,079	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,607	1,188,769	0.009764	83,258	813	73.00
76.00	03020	CARDIAC REHAB	18,860	76,922	0.245183	738	181	76.00
76.01	03021	BEHAVIORAL HEALTH	28,250	563,416	0.050141	0	0	76.01
76.02	03023	WOUND CLINIC	2,275	142,568	0.015957	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	12,793	34,304	0.372930	0	0	90.00
91.00	09100	EMERGENCY	32,488	1,302,108	0.024950	4,014	100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	187,646	0.000000	2,705	0	92.00
200.00		Total (lines 50-199)	316,544	21,317,980		685,185	8,661	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV Date/Time Prepared: 10/29/2013 1:22 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	316,544	0	0	0	316,544	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03021	BEHAVIORAL HEALTH	0	0	0	0	0	76.01
76.02	03023	WOUND CLINIC	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	316,544	0	0	0	316,544	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV Date/Time Prepared: 10/29/2013 1:22 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	681,478	0.000000	0.000000	21,775	50.00
51.00	05100	RECOVERY ROOM	0	99,041	0.000000	0.000000	2,160	51.00
53.00	05300	ANESTHESIOLOGY	0	417,384	0.758400	0.000000	13,464	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,175,510	0.000000	0.000000	98,515	54.00
60.00	06000	LABORATORY	0	6,021,003	0.000000	0.000000	179,451	60.00
64.00	06400	INTRAVENOUS THERAPY	0	138,536	0.000000	0.000000	33,776	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,471,745	0.000000	0.000000	150,580	65.00
66.00	06600	PHYSICAL THERAPY	0	2,217,937	0.000000	0.000000	22,836	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	56,616	0.000000	0.000000	5,505	67.00
68.00	06800	SPEECH PATHOLOGY	0	23,931	0.000000	0.000000	766	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	519,066	0.000000	0.000000	65,642	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,188,769	0.000000	0.000000	83,258	73.00
76.00	03020	CARDIAC REHAB	0	76,922	0.000000	0.000000	738	76.00
76.01	03021	BEHAVIORAL HEALTH	0	563,416	0.000000	0.000000	0	76.01
76.02	03023	WOUND CLINIC	0	142,568	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	34,304	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	1,302,108	0.000000	0.000000	4,014	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	187,646	0.000000	0.000000	2,705	92.00
200.00		Total (lines 50-199)	0	21,317,980			685,185	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 10/29/2013 1:22 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	10,211	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	CARDIAC REHAB	0	0	0		76.00
76.01	03021	BEHAVIORAL HEALTH	0	0	0		76.01
76.02	03023	WOUND CLINIC	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	10,211	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V Date/Time Prepared: 10/29/2013 1:22 pm

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.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.733541	0	336,903	0	0	50.00
51.00	05100	RECOVERY ROOM	0.855494	0	47,776	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.809576	0	207,264	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240274	0	2,541,405	0	0	54.00
60.00	06000	LABORATORY	0.243082	0	3,081,866	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.105619	0	38,368	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.296528	0	631,258	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.375873	0	889,913	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.517716	0	2,870	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.716477	0	14,520	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.772156	0	207,163	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.709272	0	691,291	0	0	73.00
76.00	03020	CARDIAC REHAB	1.707327	0	63,666	0	0	76.00
76.01	03021	BEHAVIORAL HEALTH	0.681008	0	521,597	0	0	76.01
76.02	03023	WOUND CLINIC	0.881439	0	103,221	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.087308	0	16,126	0	0	90.00
91.00	09100	EMERGENCY	1.380771	0	447,350	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.393875	0	130,940	0	0	92.00
200.00		Subtotal (see instructions)		0	9,973,497	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	9,973,497	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V Date/Time Prepared: 10/29/2013 1:22 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	247,132	0		50.00
51.00	05100	RECOVERY ROOM	40,872	0		51.00
53.00	05300	ANESTHESIOLOGY	167,796	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	610,634	0		54.00
60.00	06000	LABORATORY	749,146	0		60.00
64.00	06400	INTRAVENOUS THERAPY	4,052	0		64.00
65.00	06500	RESPIRATORY THERAPY	187,186	0		65.00
66.00	06600	PHYSICAL THERAPY	334,494	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,486	0		67.00
68.00	06800	SPEECH PATHOLOGY	10,403	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	159,962	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	490,313	0		73.00
76.00	03020	CARDIAC REHAB	108,699	0		76.00
76.01	03021	BEHAVIORAL HEALTH	355,212	0		76.01
76.02	03023	WOUND CLINIC	90,983	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	33,660	0		90.00
91.00	09100	EMERGENCY	617,688	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	182,514	0		92.00
200.00		Subtotal (see instructions)	4,392,232	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,392,232	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141306 | Component CCN: 14Z306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V | Date/Time Prepared: 10/29/2013 1:22 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.733541	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.855494	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.809576	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240274	0	0	0	0	54.00
60.00	06000	LABORATORY	0.243082	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.105619	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.296528	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.375873	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.517716	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.716477	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.772156	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.709272	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	1.707327	0	0	0	0	76.00
76.01	03021	BEHAVIORAL HEALTH	0.681008	0	0	0	0	76.01
76.02	03023	WOUND CLINIC	0.881439	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.087308	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.380771	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.393875	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	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	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141306 | Component CCN: 14Z306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V | Date/Time Prepared: 10/29/2013 1:22 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	76.00
76.01	03021	BEHAVIORAL HEALTH	0	0	76.01
76.02	03023	WOUND CLINIC	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	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	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 10/29/2013 1:22 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,021	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	543	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)	397	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	206	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)	261	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	11	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	318	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)	206	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)	240	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	132.03	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.03	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,810,834	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)	1,452	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	838,068	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	972,766	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	473,486	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	473,486	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	2.054477	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,192.66	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)	972,766	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)	1,791.47	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	569,687	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)	569,687	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 10/29/2013 1:22 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	479,908	134	3,581.40	112	401,117	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)	276,524	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,247,328	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)	369,043	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	429,953	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	798,996	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)	146	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,791.47	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	261,555	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 10/29/2013 1:22 pm

Title XVIII | Hospital | Cost

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-3 | Date/Time Prepared: 10/29/2013 1:22 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		228,960		30.00
31.00	03100	INTENSIVE CARE UNIT		154,228		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.733541	21,775	15,973	50.00
51.00	05100	RECOVERY ROOM	0.855494	2,160	1,848	51.00
53.00	05300	ANESTHESIOLOGY	0.809576	13,464	10,900	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240274	98,515	23,671	54.00
60.00	06000	LABORATORY	0.243082	179,451	43,621	60.00
64.00	06400	INTRAVENOUS THERAPY	0.105619	33,776	3,567	64.00
65.00	06500	RESPIRATORY THERAPY	0.296528	150,580	44,651	65.00
66.00	06600	PHYSICAL THERAPY	0.375873	22,836	8,583	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.517716	5,505	2,850	67.00
68.00	06800	SPEECH PATHOLOGY	0.716477	766	549	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.772156	65,642	50,686	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.709272	83,258	59,053	73.00
76.00	03020	CARDIAC REHAB	1.707327	738	1,260	76.00
76.01	03021	BEHAVIORAL HEALTH	0.681008	0	0	76.01
76.02	03023	WOUND CLINIC	0.881439	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.087308	0	0	90.00
91.00	09100	EMERGENCY	1.380771	4,014	5,542	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.393875	2,705	3,770	92.00
200.00		Total (sum of lines 50-94 and 96-98)		685,185	276,524	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)		685,185		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-3

Component CCN: 14Z306 | Date/Time Prepared: 10/29/2013 1:22 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.733541	0	0	50.00
51.00	05100	RECOVERY ROOM	0.855494	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.809576	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240274	14,492	3,482	54.00
60.00	06000	LABORATORY	0.243082	47,984	11,664	60.00
64.00	06400	INTRAVENOUS THERAPY	0.105619	10,900	1,151	64.00
65.00	06500	RESPIRATORY THERAPY	0.296528	71,894	21,319	65.00
66.00	06600	PHYSICAL THERAPY	0.375873	110,770	41,635	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.517716	34,360	17,789	67.00
68.00	06800	SPEECH PATHOLOGY	0.716477	2,811	2,014	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.772156	28,257	21,819	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.709272	61,178	43,392	73.00
76.00	03020	CARDIAC REHAB	1.707327	618	1,055	76.00
76.01	03021	BEHAVIORAL HEALTH	0.681008	0	0	76.01
76.02	03023	WOUND CLINIC	0.881439	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.087308	0	0	90.00
91.00	09100	EMERGENCY	1.380771	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.393875	455	634	92.00
200.00		Total (sum of lines 50-94 and 96-98)		383,719	165,954	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)		383,719		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141306	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 10/29/2013 1:22 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,392,232	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)	4,392,232	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)	4,436,154	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)	37,782	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,367,233	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)	3,031,139	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)	3,031,139	30.00
31.00	Primary payer payments	917	31.00
32.00	Subtotal (line 30 minus line 31)	3,030,222	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)	188,436	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	188,436	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	177,466	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	3,218,658	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	SEQUESTRATION	-16,049	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	3,202,609	40.00
41.00	Interim payments	3,031,417	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)	171,192	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 10/29/2013 1:22 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		942,082		2,867,226	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	04/26/2012	4,879	04/26/2012	36,681	3.01
3.02		01/23/2012	12,477	02/04/2013	127,510	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)		17,356		164,191	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)		959,438		3,031,417	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		183,427		171,192	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,142,865		3,202,609	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 10/29/2013 1:22 pm

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

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		827,201		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	02/04/2013	317		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		317		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)		827,518		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		138,473		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		965,991		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141306	Period: From 07/01/2012 To 06/30/2013	Worksheet E-1 Part II Date/Time Prepared: 10/29/2013 1:22 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	191	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	430	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	531	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	21,982,409	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	94,964	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	333,261	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	333,261	8.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	333,261	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141306 | Component CCN: 14Z306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E-2 | Date/Time Prepared: 10/29/2013 1:22 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	806,986	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)	167,614	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	446	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)	974,600	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	974,600	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)	974,600	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,768	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)	970,832	0	15.00
16.00	SEQUESTRATION	-4,841	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)	965,991	0	19.00
20.00	Interim payments	827,518	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)	138,473	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141306	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part V Date/Time Prepared: 10/29/2013 1:22 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	1,247,328	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)	1,247,328	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,259,801	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)	1,259,801	19.00
20.00	Deductibles (exclude professional component)	128,812	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	1,130,989	22.00
23.00	Coinsurance	578	23.00
24.00	Subtotal (line 22 minus line 23)	1,130,411	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	18,181	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	18,181	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	17,181	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,148,592	28.00
29.00	SEQUESTRATION	-5,727	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	1,142,865	30.00
31.00	Interim payments	959,438	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)	183,427	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G | Date/Time Prepared: 10/29/2013 1:22 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,900,123	0	0	0	1.00
2.00	Temporary investments	1,635,300	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,521,406	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,227,632	0	0	0	6.00
7.00	Inventory	238,106	0	0	0	7.00
8.00	Prepaid expenses	410,095	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	325,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,802,398	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	520,386	0	0	0	12.00
13.00	Land improvements	475,384	0	0	0	13.00
14.00	Accumulated depreciation	-243,436	0	0	0	14.00
15.00	Buildings	3,432,958	0	0	0	15.00
16.00	Accumulated depreciation	-2,531,901	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	2,468,539	0	0	0	19.00
20.00	Accumulated depreciation	-2,049,518	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	4,452,758	0	0	0	23.00
24.00	Accumulated depreciation	-3,487,893	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	746,599	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	3,783,876	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,770,245	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	946,633	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,716,878	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	14,303,152	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	542,249	0	0	0	37.00
38.00	Salaries, wages, and fees payable	853,562	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	121,046	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	122,500	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,639,357	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	504,783	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	99,070	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	603,853	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	2,243,210	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	12,059,942				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)	12,059,942	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	14,303,152	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-1 | Date/Time Prepared: 10/29/2013 1:22 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		11,430,685		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		209,018				2.00
3.00	Total (sum of line 1 and line 2)		11,639,703		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		11,639,703		0		11.00
12.00	CHANGE IN INTEREST IN NET ASSETS	-420,239		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		-420,239		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,059,942		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-2 Parts I & II Date/Time Prepared: 10/29/2013 1:22 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	289,000		289,000	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	182,130		182,130	5.00
6.00	Swing bed - NF	4,290		4,290	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)	475,420		475,420	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	189,009		189,009	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)	189,009		189,009	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	664,429		664,429	17.00
18.00	Ancillary services	1,256,813	18,537,108	19,793,921	18.00
19.00	Outpatient services	9,295	1,514,763	1,524,058	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	68,114	2,399,669	2,467,783	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,998,651	22,451,540	24,450,191	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		13,356,592		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		13,356,592		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141306 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-3 | Date/Time Prepared: 10/29/2013 1:22 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	24,450,191	1.00
2.00	Less contractual allowances and discounts on patients' accounts	11,462,173	2.00
3.00	Net patient revenues (line 1 minus line 2)	12,988,018	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	13,356,592	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-368,574	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	76,921	6.00
7.00	Income from investments	44,289	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	27,537	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	32,967	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	1,475	16.00
17.00	Revenue from sale of drugs to other than patients	3,380	17.00
18.00	Revenue from sale of medical records and abstracts	5,603	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	30,503	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	25,892	24.00
24.01	EHR INCENTIVE PAYMENTS	333,261	24.01
25.00	Total other income (sum of lines 6-24)	581,828	25.00
26.00	Total (line 5 plus line 25)	213,254	26.00
27.00	SCHOLARSHIP	2,000	27.00
27.01	LOSS ON DISPOSAL OF ASSETS	2,236	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	4,236	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	209,018	29.00