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: 141310	Period: From 04/01/2012 To 03/31/2013	Worksheet S Parts I-III Date/Time Prepared: 8/20/2013 3:08 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 8/20/2013 Time: 3:08 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 MENDOTA COMMUNITY HOSPITAL (141310) for the cost reporting period beginning 04/01/2012 and ending 03/31/2013 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	-111,588	447,639	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	1,582	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	-110,006	447,639	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: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 8/20/2013 3:08 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1401 EAST 12TH STREET	PO Box:			1.00
2.00	City: MENDOTA	State: IL	Zip Code: 61342-9216	County: LASALLE	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	MENDOTA COMMUNITY HOSPITAL	141310	99914	1	01/15/2001	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	MENDOTA COMMUNITY SWING BED- SNF	14Z310	99914		01/25/2001	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	MENDOTA COMMUNITY HOSPITAL- HHA	147616	99914		09/15/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	04/01/2012	03/31/2013	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	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 8/20/2013 3:08 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.				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.				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: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 8/20/2013 3:08 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: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 8/20/2013 3:08 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)	Y		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	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.	N			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: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 8/20/2013 3:08 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	39,499	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: 141310	Period: From 04/01/2012 To 03/31/2013	Worksheet S-2 Part I Date/Time Prepared: 8/20/2013 3:08 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.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 8/20/2013 3:08 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	07/10/2013	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: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-2 Part II Date/Time Prepared: 8/20/2013 3:08 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				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				Y	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.				Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				Y	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 8/20/2013 3:08 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)	07/10/2013			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.		SENIOR MANANGING CONSULTANT		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: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-3 Part I Date/Time Prepared: 8/20/2013 3:08 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	24,312.00	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	24,312.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	4,536.00	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	28,848.00	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: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 8/20/2013 3:08 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)	1,968	55	2,493			1.00
2.00	HMO	96	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	1,118	0	1,158			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	104			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,086	55	3,755			7.00
8.00	INTENSIVE CARE UNIT	260	9	346			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	3,346	64	4,101	0.00	264.46	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	2,302	0	2,954	0.00	6.21	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	270.67	27.00
28.00	Observation Bed Days		0	862			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: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 8/20/2013 3:08 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	544	27	746	1.00
2.00	HMO			21			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	544	27	746	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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 141310 | Component CCN: 147616 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-4 | Date/Time Prepared: 8/20/2013 3:08 pm

Home Health Agency I | PPS

		1.00	
0.00	County	LASALLE	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	428	0	50	478	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	209.00	5.00	53.00	267.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.99	0.00	0.99	4.00
5.00	Other Administrative Personnel		1.11	0.00	1.11	5.00
6.00	Direct Nursing Service		3.50	0.00	3.50	6.00
7.00	Nursing Supervisor		0.18	0.00	0.18	7.00
8.00	Physical Therapy Service		0.16	0.06	0.22	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.04	0.00	0.04	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.01	0.01	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.23	0.00	0.23	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99914			20.00

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,434	12	100	16	1,562	21.00
22.00	Skilled Nursing Visit Charges	356,142	2,988	24,888	3,984	388,002	22.00
23.00	Physical Therapy Visits	352	5	8	3	368	23.00
24.00	Physical Therapy Visit Charges	87,468	1,245	1,992	747	91,452	24.00
25.00	Occupational Therapy Visits	60	0	1	0	61	25.00
26.00	Occupational Therapy Visit Charges	14,928	0	249	0	15,177	26.00
27.00	Speech Pathology Visits	12	0	0	0	12	27.00
28.00	Speech Pathology Visit Charges	2,988	0	0	0	2,988	28.00
29.00	Medical Social Service Visits	20	0	0	0	20	29.00
30.00	Medical Social Service Visit Charges	6,986	0	0	0	6,986	30.00
31.00	Home Health Aide Visits	267	12	0	0	279	31.00
32.00	Home Health Aide Visit Charges	38,912	1,752	0	0	40,664	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,145	29	109	19	2,302	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	507,424	5,985	27,129	4,731	545,269	35.00
36.00	Total Number of Episodes (standard/non outlier)	182		38	3	223	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	35,085	0	618	300	36,003	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141310	Period: From 04/01/2012 To 03/31/2013	Worksheet S-10 Date/Time Prepared: 8/20/2013 3:08 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)	0.459512	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	631,366	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	512,313	5.00
6.00	Medicaid charges	5,167,928	6.00
7.00	Medicaid cost (line 1 times line 6)	2,374,725	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,231,046	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)	1,231,046	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	1,533,187	107,616	1,640,803	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	704,518	49,451	753,969	21.00
22.00	Partial payment by patients approved for charity care	37,785	0	37,785	22.00
23.00	Cost of charity care (line 21 minus line 22)	666,733	49,451	716,184	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)	2,046,533	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	541,391	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	1,505,142	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	691,631	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,407,815	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,638,861	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A | Date/Time Prepared: 8/20/2013 3:08 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		0	0	3,841,654	3,841,654	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,591,345	3,591,345	-1,666,613	1,924,732	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	0	3,440,356	3,440,356	338,797	3,779,153	4.00
5.01	00510	BUSINESS OFFICE	247,539	132,609	380,148	210,007	590,155	5.01
5.02	00511	DATA PROCESSING	384,364	407,417	791,781	0	791,781	5.02
5.03	00512	ADMITTING	144,757	8,040	152,797	0	152,797	5.03
5.04	00513	PURCHASING, RECEIVING & STORES	93,649	30,029	123,678	0	123,678	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	973,987	1,636,017	2,610,004	-407,019	2,202,985	5.05
7.00	00700	OPERATION OF PLANT	431,667	639,500	1,071,167	2,731	1,073,898	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	88,113	88,113	0	88,113	8.00
9.00	00900	HOUSEKEEPING	366,330	62,304	428,634	0	428,634	9.00
10.00	01000	DIETARY	303,124	174,869	477,993	-315,875	162,118	10.00
11.00	01100	CAFETERIA	0	0	0	315,875	315,875	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	201,418	201,418	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	248,317	121,312	369,629	0	369,629	16.00
17.00	01700	SOCIAL SERVICE	204,289	5,201	209,490	0	209,490	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,865,014	282,223	2,147,237	0	2,147,237	30.00
31.00	03100	INTENSIVE CARE UNIT	580,987	123,053	704,040	0	704,040	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	470,883	641,117	1,112,000	-279,505	832,495	50.00
51.00	05100	RECOVERY ROOM	61,895	44,539	106,434	0	106,434	51.00
53.00	05300	ANESTHESIOLOGY	669,400	122,870	792,270	-10,317	781,953	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	604,894	1,002,418	1,607,312	-100,300	1,507,012	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,019	1,019	65,903	66,922	58.00
60.00	06000	LABORATORY	744,238	824,926	1,569,164	0	1,569,164	60.00
65.00	06500	RESPIRATORY THERAPY	525,607	64,451	590,058	-30,537	559,521	65.00
66.00	06600	PHYSICAL THERAPY	354,477	22,852	377,329	-14,386	362,943	66.00
67.00	06700	OCCUPATIONAL THERAPY	101,142	79,987	181,129	-4,127	177,002	67.00
68.00	06800	SPEECH PATHOLOGY	0	50,175	50,175	0	50,175	68.00
69.00	06900	ELECTROCARDIOLOGY	38,113	146,012	184,125	0	184,125	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	62,475	118,758	181,233	295,292	476,525	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	277,144	872,607	1,149,751	75,245	1,224,996	73.00
75.00	07500	ASC (NON-DISTINCT PART)	170,638	22,636	193,274	0	193,274	75.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	302,695	303,627	606,322	-93,680	512,642	90.00
91.00	09100	EMERGENCY	839,708	2,013,168	2,852,876	0	2,852,876	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	347,657	82,775	430,432	-5,451	424,981	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		2,202,160	2,202,160	-2,202,160	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,414,990	19,358,485	30,773,475	216,952	30,990,427	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	3,175,269	499,357	3,674,626	-132,002	3,542,624	192.00
192.01	19201	MARKETING	21,291	91,178	112,469	-84,620	27,849	192.01
192.02	19202	FOUNDATION	40,147	39,536	79,683	-330	79,353	192.02
200.00		TOTAL (SUM OF LINES 118-199)	14,651,697	19,988,556	34,640,253	0	34,640,253	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A | Date/Time Prepared: 8/20/2013 3:08 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	-490,067	3,351,587		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-38,981	1,885,751		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS	-49,302	3,729,851		4.00
5.01	00510	BUSINESS OFFICE	0	590,155		5.01
5.02	00511	DATA PROCESSING	0	791,781		5.02
5.03	00512	ADMITTING	0	152,797		5.03
5.04	00513	PURCHASING, RECEIVING & STORES	0	123,678		5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	-741,164	1,461,821		5.05
7.00	00700	OPERATION OF PLANT	0	1,073,898		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	88,113		8.00
9.00	00900	HOUSEKEEPING	0	428,634		9.00
10.00	01000	DIETARY	-6,435	155,683		10.00
11.00	01100	CAFETERIA	-99,958	215,917		11.00
13.00	01300	NURSING ADMINISTRATION	0	201,418		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9,147	360,482		16.00
17.00	01700	SOCIAL SERVICE	0	209,490		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,147,237		30.00
31.00	03100	INTENSIVE CARE UNIT	0	704,040		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-23,097	809,398		50.00
51.00	05100	RECOVERY ROOM	0	106,434		51.00
53.00	05300	ANESTHESIOLOGY	-685,745	96,208		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,507,012		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	66,922		58.00
60.00	06000	LABORATORY	-3,529	1,565,635		60.00
65.00	06500	RESPIRATORY THERAPY	0	559,521		65.00
66.00	06600	PHYSICAL THERAPY	0	362,943		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	177,002		67.00
68.00	06800	SPEECH PATHOLOGY	0	50,175		68.00
69.00	06900	ELECTROCARDIOLOGY	-109,706	74,419		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	476,525		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,224,996		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	193,274		75.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-171,050	341,592		90.00
91.00	09100	EMERGENCY	-845,878	2,006,998		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	424,981		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,274,059	27,716,368		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,542,624		192.00
192.01	19201	MARKETING	0	27,849		192.01
192.02	19202	FOUNDATION	0	79,353		192.02
200.00		TOTAL (SUM OF LINES 118-199)	-3,274,059	31,366,194		200.00

RECLASSIFICATIONS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-6 | Date/Time Prepared: 8/20/2013 3:08 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,010,895	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	159,952	2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	31,313	3.00
	TOTALS		0	2,202,160	
	B - TO RECLASS COPIER LEASE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,050	1.00
	TOTALS		0	3,050	
	C - TO RECLASS UTILITY EXPENSE				
1.00	OPERATION OF PLANT	7.00	0	5,717	1.00
	TOTALS		0	5,717	
	D - TO RECLASS CAFETERIA COSTS				
1.00	CAFETERIA	11.00	200,315	115,560	1.00
	TOTALS		200,315	115,560	
	E - TO RECLASS CLINIC EXPENSE				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	62,867	1.00
	TOTALS		0	62,867	
	F - TO RECLASS BUILDING DEPRECIATION EXP				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,770,213	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	65,165	2.00
	TOTALS		0	1,835,378	
	G - TO RECLASS PHY CLINIC OFF EQUIP DEPR				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,746	1.00
	TOTALS		0	2,746	
	H - TO RECLASS PROPERTY INSURANCE EXPENS				
1.00	OTHER CAP REL COSTS	3.00	0	29,481	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	26,037	2.00
	TOTALS		0	55,518	
	I - TO RECLASS WORKERS COMP				
1.00	EMPLOYEE BENEFITS	4.00	0	118,398	1.00
	TOTALS		0	118,398	
	J - TO RECLASS HUMAN RESOURSE EXPENSE				
1.00	EMPLOYEE BENEFITS	4.00	63,181	157,218	1.00
	TOTALS		63,181	157,218	
	K - TO RECLASS IMPLANTS & OXYGEN EXPENSE				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	301,957	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	301,957	
	L - TO RECLASS DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	75,245	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		0	75,245	
	M - TO RECLASS CENTRALIZED BILLING EXP				
1.00	BUSINESS OFFICE	5.01	74,726	135,281	1.00
	TOTALS		74,726	135,281	
	N - TO RECLASS RADIOLOGY CONT EQUIPMENT				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,825	1.00
	TOTALS		0	4,825	
	O - TO RECLASS NURSING ADMIN EXPENSES				
1.00	NURSING ADMINISTRATION	13.00	201,418	0	1.00
	TOTALS		201,418	0	
	P - TO RECLASS ADVERTISING EXPENSE				
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	198,511	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		0	198,511	
	Q - RECLASS PT & OT SALARIES TO HHA				
1.00	HOME HEALTH AGENCY	101.00	18,513	0	1.00
2.00		0.00	0	0	2.00
	TOTALS		18,513	0	
	R - TO RECLASS PHYSICIAN PLANT MAINT EXP				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	2,986	0	1.00
	TOTALS		2,986	0	

RECLASSIFICATIONS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-6 | Date/Time Prepared: 8/20/2013 3:08 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	S - TO RECLASS HHA RENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,712		1.00
	TOTALS		0	8,712		
			0	0		
	U - TO RECLASS MRI SALARY					
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	65,903	0		1.00
	TOTALS		65,903	0		
	V - RECLASS PHYSICIAN ADMIN COSTS					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	24,807	0		1.00
	TOTALS		24,807	0		
500.00	Grand Total: Increases		651,849	5,283,143		500.00

RECLASSIFICATIONS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-6 | Date/Time Prepared: 8/20/2013 3:08 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	2,202,160	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	2,202,160			
	B - TO RECLASS COPIER LEASE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	3,050	10		1.00
	TOTALS		0	3,050			
	C - TO RECLASS UTILITY EXPENSE						
1.00	HOME HEALTH AGENCY	101.00	0	5,717	0		1.00
	TOTALS		0	5,717			
	D - TO RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	200,315	115,560	0		1.00
	TOTALS		200,315	115,560			
	E - TO RECLASS CLINIC EXPENSE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	62,867	0		1.00
	TOTALS		0	62,867			
	F - TO RECLASS BUILDING DEPRECIATION EXP						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,835,378	9		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	1,835,378			
	G - TO RECLASS PHY CLINIC OFF EQUIP DEPR						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,746	9		1.00
	TOTALS		0	2,746			
	H - TO RECLASS PROPERTY INSURANCE EXPENS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	29,481	0		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	26,037	11		2.00
	TOTALS		0	55,518			
	I - TO RECLASS WORKERS COMP						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	118,398	0		1.00
	TOTALS		0	118,398			
	J - TO RECLASS HUMAN RESOURSE EXPENSE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	63,181	157,218	0		1.00
	TOTALS		63,181	157,218			
	K - TO RECLASS IMPLANTS & OXYGEN EXPENSE						
1.00	OPERATING ROOM	50.00	0	279,505	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	22,452	0		2.00
	TOTALS		0	301,957			
	L - TO RECLASS DRUGS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,665	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	10,317	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	29,572	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	8,085	0		4.00
5.00	CLINIC	90.00	0	20,606	0		5.00
	TOTALS		0	75,245			
	M - TO RECLASS CENTRALIZED BILLING EXP						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	74,726	135,281	0		1.00
	TOTALS		74,726	135,281			
	N - TO RECLASS RADIOLOGY CONT EQUIPMENT						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,825	10		1.00
	TOTALS		0	4,825			
	O - TO RECLASS NURSING ADMIN EXPENSES						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	201,418	0	0		1.00
	TOTALS		201,418	0			
	P - TO RECLASS ADVERTISING EXPENSE						
1.00	HOME HEALTH AGENCY	101.00	0	9,535	0		1.00
2.00	CLINIC	90.00	0	73,074	0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	30,952	0		3.00
4.00	MARKETING	192.01	0	84,620	0		4.00
5.00	FOUNDATION	192.02	0	330	0		5.00
	TOTALS		0	198,511			
	Q - RECLASS PT & OT SALARIES TO HHA						
1.00	PHYSICAL THERAPY	66.00	14,386	0	0		1.00
2.00	OCCUPATIONAL THERAPY	67.00	4,127	0	0		2.00
	TOTALS		18,513	0			

RECLASSIFICATIONS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-6 | Date/Time Prepared: 8/20/2013 3:08 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	R - TO RECLASS PHYSICIAN PLANT MAINT EXP						
1.00	OPERATION OF PLANT	7.00	2,986	0	0		1.00
	TOTALS		2,986	0			
	S - TO RECLASS HHA RENT						
1.00	HOME HEALTH AGENCY	101.00	0	8,712	10		1.00
	TOTALS		0	8,712			
			0	0			
	U - TO RECLASS MRI SALARY						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	65,903	0	0		1.00
	TOTALS		65,903	0			
	V - RECLASS PHYSICIAN ADMIN COSTS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	24,807	0	0		1.00
	TOTALS		24,807	0			
500.00	Grand Total: Decreases		651,849	5,283,143			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-7 Part I | Date/Time Prepared: 8/20/2013 3:08 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,282,124	0	0	0	-10,000	1.00
2.00	Land Improvements	4,784,309	192,792	0	192,792	0	2.00
3.00	Buildings and Fixtures	30,549,468	305,892	0	305,892	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	4,109,989	145,591	0	145,591	0	5.00
6.00	Movable Equipment	9,985,495	607,660	0	607,660	64,576	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	50,711,385	1,251,935	0	1,251,935	54,576	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	50,711,385	1,251,935	0	1,251,935	54,576	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,292,124	0	1.00
2.00	Land Improvements	4,977,101	0	2.00
3.00	Buildings and Fixtures	30,855,360	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,255,580	0	5.00
6.00	Movable Equipment	10,528,579	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	51,908,744	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	51,908,744	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-7 Part II | Date/Time Prepared: 8/20/2013 3:08 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	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,591,345	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,591,345	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	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,591,345		2.00
3.00	Total (sum of lines 1-2)	0	3,591,345		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-7 Part III | Date/Time Prepared: 8/20/2013 3:08 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	41,380,165	0	41,380,165	0.875049	25,797	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,528,579	4,619,780	5,908,799	0.124951	3,684	2.00
3.00	Total (sum of lines 1-2)	51,908,744	4,619,780	47,288,964	1.000000	29,481	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	25,797	1,770,213	8,712	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	3,684	1,753,221	7,875	2.00
3.00	Total (sum of lines 1-2)	0	0	29,481	3,523,434	16,587	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	1,546,865	25,797	0	0	3,351,587	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	120,971	3,684	0	0	1,885,751	2.00
3.00	Total (sum of lines 1-2)	1,667,836	29,481	0	0	5,237,338	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-8 | Date/Time Prepared: 8/20/2013 3:08 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)	B	-490,067	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-38,981	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-7,631	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-462	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-21,366	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-35,155	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,827,400			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	-72,495	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		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-9,147	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	B	-1,834	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	DIETARY REVENUE	B	-6,435	DIETARY	10.00	0	33.00
33.01	MEALS ON WHEELS	B	-25,629	CAFETERIA	11.00	0	33.01
33.02	AMBULANCE SUPPLY REVENUE	B	-11,605	EMERGENCY	91.00	0	33.02

ADJUSTMENTS TO EXPENSES | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-8 | Date/Time Prepared: 8/20/2013 3:08 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	
33.03	LAB QUALITY CN REVENUE	B	-13,299	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.03
33.04	FARM INCOME	B	-12,366	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.04
33.05	MISCELLANEOUS INCOME	B	-18,868	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.05
33.06	CABLE TV EXPENSE	A	-4,340	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.06
33.07	ADVERTISING EXPENSE	A	-193,503	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.07
33.08	COMMUNITY HEALTH EXPENSE	A	-3,898	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.08
33.09	COMMUNITY HEATLH BENEFIT EXPENSE	A	-25	EMPLOYEE BENEFITS	4.00	0	33.09
33.10	LOBBYING EXPENSE	A	-11,953	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.10
33.11	CRNA BENEFIT EXPENSE	A	-49,277	EMPLOYEE BENEFITS	4.00	0	33.11
33.12	PROVIDER TAX IDPA EXPENSE	A	-207,679	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.12
33.13	PHYSICIAN MALPRACTICE INSURANCE	A	-178,037	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.13
33.14	PRHSICIAN RECRUITING EXPENSE	A	-32,607	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,274,059				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-8-2 | Date/Time Prepared: 8/20/2013 3:08 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	30,000	3,529	26,471	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	109,706	109,706	0	0	0	2.00
3.00	91.00	EMERGENCY	1,661,416	834,273	827,143	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	685,745	685,745	0	0	0	4.00
5.00	90.00	CLINIC	171,050	171,050	0	0	0	5.00
6.00	50.00	OPERATING ROOM	23,097	23,097	0	0	0	6.00
7.00	5.05	OTHER ADMINISTRATIVE AND GENERAL	24,807	0	24,807	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			2,705,821	1,827,400	878,421		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	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	5.05	OTHER ADMINISTRATIVE AND GENERAL	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	3,529		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	109,706		2.00
3.00	91.00	EMERGENCY	0	0	0	834,273		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	685,745		4.00
5.00	90.00	CLINIC	0	0	0	171,050		5.00
6.00	50.00	OPERATING ROOM	0	0	0	23,097		6.00
7.00	5.05	OTHER ADMINISTRATIVE AND GENERAL	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	1,827,400		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/20/2013 3:08 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					4	1.00
2.00	Line 1 multiplied by 15 hours per week					60	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	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)					65	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	131.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.83	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.92	36.92	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					9,672	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)					9,672	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)					9,672	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)					9,672	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)					0	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)					0	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)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	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)					0	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)					2,400	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					2,400	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					358	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: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/20/2013 3:08 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)	73.83	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	9,672	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	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)	9,672	63.00
64.00	Total cost of outside supplier services (from your records)	8,515	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	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	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	0	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	0	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: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/20/2013 3:08 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		32	1.00
2.00	Line 1 multiplied by 15 hours per week		480	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		150	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	1,151.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	69.97	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.99	34.99	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	80,535	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)	80,535	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)	80,535	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)	80,535	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)	5,249	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)	5,249	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)	825	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	6,074	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)	6,074	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: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/20/2013 3:08 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)	69.97	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	80,535	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	6,074	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)	86,609	63.00
64.00	Total cost of outside supplier services (from your records)	66,054	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	5,249	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	825	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	6,074	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	825	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	825	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: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/20/2013 3:08 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)					134	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	836.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	67.24	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.62	33.62	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					56,229	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)					56,229	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)					56,229	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)					56,229	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					4,505	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)					4,505	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)					737	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					5,242	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					5,242	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: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/20/2013 3:08 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)	67.24	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	56,229	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	5,242	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)	61,471	63.00
64.00	Total cost of outside supplier services (from your records)	49,726	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	4,505	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	737	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	5,242	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	737	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	737	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: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B Part I | Date/Time Prepared: 8/20/2013 3:08 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,351,587	3,351,587				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,885,751		1,885,751			2.00
4.00	00400	EMPLOYEE BENEFITS	3,729,851	4,672	2,971	3,737,494		4.00
5.01	00510	BUSINESS OFFICE	590,155	44,066	28,021	86,534	748,776	5.01
5.02	00511	DATA PROCESSING	791,781	51,455	32,719	103,208	979,163	5.02
5.03	00512	ADMITTING	152,797	27,169	17,276	38,870	236,112	5.03
5.04	00513	PURCHASING, RECEIVING & STORES	123,678	12,060	7,669	25,146	168,553	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	1,461,821	644,989	410,141	197,115	2,714,066	5.05
7.00	00700	OPERATION OF PLANT	1,073,898	148,533	94,450	115,108	1,431,989	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	88,113	15,705	9,986	0	113,804	8.00
9.00	00900	HOUSEKEEPING	428,634	36,247	23,049	98,366	586,296	9.00
10.00	01000	DIETARY	155,683	90,154	57,327	27,606	330,770	10.00
11.00	01100	CAFETERIA	215,917	35,584	22,627	53,788	327,916	11.00
13.00	01300	NURSING ADMINISTRATION	201,418	11,762	7,479	54,084	274,743	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	360,482	29,389	18,688	66,677	475,236	16.00
17.00	01700	SOCIAL SERVICE	209,490	9,907	6,299	54,855	280,551	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,147,237	506,166	321,862	500,788	3,476,053	30.00
31.00	03100	INTENSIVE CARE UNIT	704,040	76,669	48,752	156,005	985,466	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	809,398	144,822	92,090	126,440	1,172,750	50.00
51.00	05100	RECOVERY ROOM	106,434	25,611	16,286	16,620	164,951	51.00
53.00	05300	ANESTHESIOLOGY	96,208	4,274	2,718	0	103,200	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,507,012	164,801	104,794	144,728	1,921,335	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	66,922	34,358	21,848	17,696	140,824	58.00
60.00	06000	LABORATORY	1,565,635	62,886	39,988	199,841	1,868,350	60.00
65.00	06500	RESPIRATORY THERAPY	559,521	71,732	45,613	141,134	818,000	65.00
66.00	06600	PHYSICAL THERAPY	362,943	65,934	41,926	91,320	562,123	66.00
67.00	06700	OCCUPATIONAL THERAPY	177,002	19,714	12,536	26,050	235,302	67.00
68.00	06800	SPEECH PATHOLOGY	50,175	3,346	2,128	0	55,649	68.00
69.00	06900	ELECTROCARDIOLOGY	74,419	3,380	2,149	10,234	90,182	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	476,525	92,672	58,928	16,776	644,901	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,224,996	26,208	16,665	74,418	1,342,287	73.00
75.00	07500	ASC (NON-DISTINCT PART)	193,274	136,870	87,034	45,819	462,997	75.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	341,592	148,831	94,639	81,279	666,341	90.00
91.00	09100	EMERGENCY	2,006,998	163,940	104,247	225,476	2,500,661	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	424,981	39,759	25,282	98,323	588,345	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,716,368	2,953,665	1,878,187	2,894,304	26,467,692	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,018	5,099	0	13,117	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,542,624	386,027	0	826,693	4,755,344	192.00
192.01	19201	MARKETING	27,849	1,955	1,243	5,717	36,764	192.01
192.02	19202	FOUNDATION	79,353	1,922	1,222	10,780	93,277	192.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	31,366,194	3,351,587	1,885,751	3,737,494	31,366,194	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B Part I Date/Time Prepared: 8/20/2013 3:08 pm

		Cost Center Description	BUSINESS OFFICE	DATA PROCESSING	Subtotal	ADMITTING	PURCHASING, RECEIVING & STORES	
			5.01	5.02	5A.02	5.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	BUSINESS OFFICE	748,776					5.01
5.02	00511	DATA PROCESSING	23,946	1,003,109				5.02
5.03	00512	ADMITTING	5,774	6,366	248,252	248,252		5.03
5.04	00513	PURCHASING, RECEIVING & STORES	4,122	0	172,675	1,645	174,320	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	66,375	75,406	2,855,847	27,213	5,698	5.05
7.00	00700	OPERATION OF PLANT	35,021	0	1,467,010	13,979	3,354	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,783	0	116,587	1,111	0	8.00
9.00	00900	HOUSEKEEPING	14,338	0	600,634	5,723	2,962	9.00
10.00	01000	DIETARY	8,089	5,300	344,159	3,279	609	10.00
11.00	01100	CAFETERIA	8,020	10,325	346,261	3,300	1,187	11.00
13.00	01300	NURSING ADMINISTRATION	6,719	2,582	284,044	2,707	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,622	240,760	727,618	6,933	484	16.00
17.00	01700	SOCIAL SERVICE	6,861	9,254	296,666	2,827	235	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	85,010	223,138	3,784,201	36,049	16,238	30.00
31.00	03100	INTENSIVE CARE UNIT	24,101	42,183	1,051,750	10,022	861	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,681	6,507	1,207,938	11,510	30,400	50.00
51.00	05100	RECOVERY ROOM	4,034	0	168,985	1,610	0	51.00
53.00	05300	ANESTHESIOLOGY	2,524	803	106,527	1,015	6,729	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,988	65,429	2,033,752	19,380	2,636	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,444	12,818	157,086	1,497	517	58.00
60.00	06000	LABORATORY	45,692	8,750	1,922,792	18,322	58,765	60.00
65.00	06500	RESPIRATORY THERAPY	20,005	47,959	885,964	8,442	2,688	65.00
66.00	06600	PHYSICAL THERAPY	13,747	1,206	577,076	5,499	2,385	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,755	992	242,049	2,306	1,539	67.00
68.00	06800	SPEECH PATHOLOGY	1,361	521	57,531	548	61	68.00
69.00	06900	ELECTROCARDIOLOGY	2,205	0	92,387	880	1,376	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,772	0	660,673	6,296	490	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,827	25,562	1,400,676	13,347	895	73.00
75.00	07500	ASC (NON-DISTINCT PART)	11,323	589	474,909	4,525	2,149	75.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	16,296	0	682,637	6,505	3,198	90.00
91.00	09100	EMERGENCY	61,156	9,550	2,571,367	24,503	12,490	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	14,389	14,386	617,120	5,881	1,500	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	628,980	810,386	26,155,173	246,854	159,446	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	321	0	13,438	128	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	116,295	192,723	5,064,362	0	14,429	192.00
192.01	19201	MARKETING	899	0	37,663	359	165	192.01
192.02	19202	FOUNDATION	2,281	0	95,558	911	280	192.02
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)	748,776	1,003,109	31,366,194	248,252	174,320	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B Part I | Date/Time Prepared: 8/20/2013 3:08 pm

		Cost Center Description	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.04	5.05	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	BUSINESS OFFICE						5.01
5.02	00511	DATA PROCESSING						5.02
5.03	00512	ADMITTING						5.03
5.04	00513	PURCHASING, RECEIVING & STORES						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	2,888,758	2,888,758				5.05
7.00	00700	OPERATION OF PLANT	1,484,343	150,572	1,634,915			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	117,698	11,939	10,616	140,253		8.00
9.00	00900	HOUSEKEEPING	609,319	61,809	24,502	0	695,630	9.00
10.00	01000	DIETARY	348,047	35,306	60,941	0	0	10.00
11.00	01100	CAFETERIA	350,748	35,580	24,054	0	25,480	11.00
13.00	01300	NURSING ADMINISTRATION	286,751	29,088	7,951	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	735,035	74,562	19,866	0	2,831	16.00
17.00	01700	SOCIAL SERVICE	299,728	30,404	6,697	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,836,488	389,173	342,148	61,248	167,869	30.00
31.00	03100	INTENSIVE CARE UNIT	1,062,633	107,793	51,825	6,184	22,816	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,249,848	126,785	97,895	14,964	50,628	50.00
51.00	05100	RECOVERY ROOM	170,595	17,305	17,312	0	8,993	51.00
53.00	05300	ANESTHESIOLOGY	114,271	11,592	2,889	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,055,768	208,537	111,400	8,050	42,967	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	159,100	16,139	23,225	1,577	8,493	58.00
60.00	06000	LABORATORY	1,999,879	202,868	42,508	0	17,487	60.00
65.00	06500	RESPIRATORY THERAPY	897,094	91,001	48,488	1,752	16,321	65.00
66.00	06600	PHYSICAL THERAPY	584,960	59,338	44,569	8,475	13,157	66.00
67.00	06700	OCCUPATIONAL THERAPY	245,894	24,943	13,326	2,462	3,830	67.00
68.00	06800	SPEECH PATHOLOGY	58,140	5,898	2,262	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	94,643	9,601	2,284	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	667,459	67,707	62,643	129	4,163	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,414,918	143,529	17,716	0	7,328	73.00
75.00	07500	ASC (NON-DISTINCT PART)	481,583	48,852	92,520	5,185	47,963	75.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	692,340	70,231	100,605	788	24,814	90.00
91.00	09100	EMERGENCY	2,608,360	264,592	110,817	27,860	59,288	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	624,501	63,349	26,876	0	6,995	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,138,901	2,358,493	1,365,935	138,674	531,423	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,566	1,376	5,420	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,078,791	515,201	260,940	1,579	164,207	192.00
192.01	19201	MARKETING	38,187	3,874	1,321	0	0	192.01
192.02	19202	FOUNDATION	96,749	9,814	1,299	0	0	192.02
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)	31,366,194	2,888,758	1,634,915	140,253	695,630	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B Part I | Date/Time Prepared: 8/20/2013 3:08 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	BUSINESS OFFICE						5.01
5.02	00511	DATA PROCESSING						5.02
5.03	00512	ADMITTING						5.03
5.04	00513	PURCHASING, RECEIVING & STORES						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
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	444,294					10.00
11.00	01100	CAFETERIA	0	435,862				11.00
13.00	01300	NURSING ADMINISTRATION	0	4,637	328,427			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,229	0	848,523		16.00
17.00	01700	SOCIAL SERVICE	0	9,274	0	0	346,103	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	393,122	99,695	163,729	303,862	293,355	30.00
31.00	03100	INTENSIVE CARE UNIT	30,150	20,866	34,650	4,828	8,521	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	20,866	21,963	0	0	50.00
51.00	05100	RECOVERY ROOM	0	2,318	2,305	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,184	0	98,371	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,318	0	19,312	0	58.00
60.00	06000	LABORATORY	0	37,095	0	12,070	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	23,184	0	15,993	0	65.00
66.00	06600	PHYSICAL THERAPY	0	13,910	0	4,526	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,318	0	3,621	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	604	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,318	1,557	9,958	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,955	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,955	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	12,933	6,955	8,797	51,901	23,939	75.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,847	16,229	13,821	99,276	0	90.00
91.00	09100	EMERGENCY	5,242	41,731	58,306	130,658	15,013	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	20,037	0	5,275	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	444,294	357,037	325,165	754,980	346,103	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	74,189	3,262	93,543	0	192.00
192.01	19201	MARKETING	0	2,318	0	0	0	192.01
192.02	19202	FOUNDATION	0	2,318	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	444,294	435,862	328,427	848,523	346,103	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B Part I | Date/Time Prepared: 8/20/2013 3:08 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
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	BUSINESS OFFICE					5.01
5.02	00511	DATA PROCESSING					5.02
5.03	00512	ADMITTING					5.03
5.04	00513	PURCHASING, RECEIVING & STORES					5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL					5.05
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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	6,050,689	0	6,050,689		30.00
31.00	03100	INTENSIVE CARE UNIT	1,350,266	0	1,350,266		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,582,949	0	1,582,949		50.00
51.00	05100	RECOVERY ROOM	218,828	0	218,828		51.00
53.00	05300	ANESTHESIOLOGY	128,752	0	128,752		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,548,277	0	2,548,277		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	230,164	0	230,164		58.00
60.00	06000	LABORATORY	2,311,907	0	2,311,907		60.00
65.00	06500	RESPIRATORY THERAPY	1,093,833	0	1,093,833		65.00
66.00	06600	PHYSICAL THERAPY	728,935	0	728,935		66.00
67.00	06700	OCCUPATIONAL THERAPY	296,394	0	296,394		67.00
68.00	06800	SPEECH PATHOLOGY	66,904	0	66,904		68.00
69.00	06900	ELECTROCARDIOLOGY	120,361	0	120,361		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	809,056	0	809,056		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,590,446	0	1,590,446		73.00
75.00	07500	ASC (NON-DISTINCT PART)	780,628	0	780,628		75.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,020,951	0	1,020,951		90.00
91.00	09100	EMERGENCY	3,321,867	0	3,321,867		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	747,033	0	747,033		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,998,240	0	24,998,240		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,362	0	20,362		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,191,712	0	6,191,712		192.00
192.01	19201	MARKETING	45,700	0	45,700		192.01
192.02	19202	FOUNDATION	110,180	0	110,180		192.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	31,366,194	0	31,366,194		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B Part II Date/Time Prepared: 8/20/2013 3:08 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	4,672	2,971	7,643	7,643	4.00
5.01	00510	BUSINESS OFFICE	0	44,066	28,021	72,087	177	5.01
5.02	00511	DATA PROCESSING	0	51,455	32,719	84,174	211	5.02
5.03	00512	ADMITTING	0	27,169	17,276	44,445	79	5.03
5.04	00513	PURCHASING, RECEIVING & STORES	0	12,060	7,669	19,729	51	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	0	644,989	410,141	1,055,130	403	5.05
7.00	00700	OPERATION OF PLANT	0	148,533	94,450	242,983	235	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,705	9,986	25,691	0	8.00
9.00	00900	HOUSEKEEPING	0	36,247	23,049	59,296	201	9.00
10.00	01000	DIETARY	0	90,154	57,327	147,481	56	10.00
11.00	01100	CAFETERIA	0	35,584	22,627	58,211	110	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,762	7,479	19,241	111	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,389	18,688	48,077	136	16.00
17.00	01700	SOCIAL SERVICE	0	9,907	6,299	16,206	112	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	506,166	321,862	828,028	1,024	30.00
31.00	03100	INTENSIVE CARE UNIT	0	76,669	48,752	125,421	319	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	144,822	92,090	236,912	259	50.00
51.00	05100	RECOVERY ROOM	0	25,611	16,286	41,897	34	51.00
53.00	05300	ANESTHESIOLOGY	0	4,274	2,718	6,992	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	164,801	104,794	269,595	296	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	34,358	21,848	56,206	36	58.00
60.00	06000	LABORATORY	0	62,886	39,988	102,874	409	60.00
65.00	06500	RESPIRATORY THERAPY	0	71,732	45,613	117,345	289	65.00
66.00	06600	PHYSICAL THERAPY	0	65,934	41,926	107,860	187	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	19,714	12,536	32,250	53	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,346	2,128	5,474	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,380	2,149	5,529	21	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	92,672	58,928	151,600	34	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	26,208	16,665	42,873	152	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	136,870	87,034	223,904	94	75.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	148,831	94,639	243,470	166	90.00
91.00	09100	EMERGENCY	0	163,940	104,247	268,187	461	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	39,759	25,282	65,041	201	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,953,665	1,878,187	4,831,852	5,917	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,018	5,099	13,117	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	77,664	386,027	0	463,691	1,692	192.00
192.01	19201	MARKETING	0	1,955	1,243	3,198	12	192.01
192.02	19202	FOUNDATION	0	1,922	1,222	3,144	22	192.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	77,664	3,351,587	1,885,751	5,315,002	7,643	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B Part II | Date/Time Prepared: 8/20/2013 3:08 pm

		Cost Center Description	BUSINESS OFFICE	DATA PROCESSING	ADMITTING	PURCHASING, RECEIVING & STORES	OTHER ADMINISTRATIVE AND GENERAL	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	BUSINESS OFFICE	72,264					5.01
5.02	00511	DATA PROCESSING	2,311	86,696				5.02
5.03	00512	ADMITTING	557	550	45,631			5.03
5.04	00513	PURCHASING, RECEIVING & STORES	398	0	302	20,480		5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	6,405	6,517	5,001	669	1,074,125	5.05
7.00	00700	OPERATION OF PLANT	3,379	0	2,569	394	55,986	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	269	0	204	0	4,439	8.00
9.00	00900	HOUSEKEEPING	1,384	0	1,052	348	22,982	9.00
10.00	01000	DIETARY	781	458	603	72	13,128	10.00
11.00	01100	CAFETERIA	774	892	606	139	13,230	11.00
13.00	01300	NURSING ADMINISTRATION	648	223	497	0	10,816	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,122	20,811	1,274	57	27,724	16.00
17.00	01700	SOCIAL SERVICE	662	800	519	28	11,305	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,203	19,285	6,636	1,908	144,705	30.00
31.00	03100	INTENSIVE CARE UNIT	2,326	3,646	1,842	101	40,080	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,768	562	2,115	3,572	47,142	50.00
51.00	05100	RECOVERY ROOM	389	0	296	0	6,435	51.00
53.00	05300	ANESTHESIOLOGY	244	69	187	791	4,310	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,534	5,655	3,561	310	77,539	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	332	1,108	275	61	6,001	58.00
60.00	06000	LABORATORY	4,409	756	3,367	6,903	75,431	60.00
65.00	06500	RESPIRATORY THERAPY	1,930	4,145	1,551	316	33,837	65.00
66.00	06600	PHYSICAL THERAPY	1,327	104	1,010	280	22,064	66.00
67.00	06700	OCCUPATIONAL THERAPY	555	86	424	181	9,275	67.00
68.00	06800	SPEECH PATHOLOGY	131	45	101	7	2,193	68.00
69.00	06900	ELECTROCARDIOLOGY	213	0	162	162	3,570	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,522	0	1,157	58	25,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,168	2,209	2,453	105	53,368	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,093	51	832	252	18,164	75.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,573	0	1,195	376	26,114	90.00
91.00	09100	EMERGENCY	5,902	825	4,502	1,467	98,382	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,388	1,243	1,081	176	23,555	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	60,697	70,040	45,374	18,733	876,950	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31	0	24	0	512	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,229	16,656	0	1,695	191,574	192.00
192.01	19201	MARKETING	87	0	66	19	1,440	192.01
192.02	19202	FOUNDATION	220	0	167	33	3,649	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	72,264	86,696	45,631	20,480	1,074,125	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B Part II | Date/Time Prepared: 8/20/2013 3:08 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
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	BUSINESS OFFICE						5.01
5.02	00511	DATA PROCESSING						5.02
5.03	00512	ADMITTING						5.03
5.04	00513	PURCHASING, RECEIVING & STORES						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	305,546					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,984	32,587				8.00
9.00	00900	HOUSEKEEPING	4,579	0	89,842			9.00
10.00	01000	DIETARY	11,389	0	0	173,968		10.00
11.00	01100	CAFETERIA	4,495	0	3,291	0	81,748	11.00
13.00	01300	NURSING ADMINISTRATION	1,486	0	0	0	870	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,713	0	366	0	3,044	16.00
17.00	01700	SOCIAL SERVICE	1,252	0	0	0	1,739	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	63,944	14,231	21,680	153,930	18,699	30.00
31.00	03100	INTENSIVE CARE UNIT	9,686	1,437	2,947	11,806	3,913	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,295	3,477	6,539	0	3,913	50.00
51.00	05100	RECOVERY ROOM	3,235	0	1,161	0	435	51.00
53.00	05300	ANESTHESIOLOGY	540	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,819	1,870	5,549	0	4,348	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,340	366	1,097	0	435	58.00
60.00	06000	LABORATORY	7,944	0	2,258	0	6,957	60.00
65.00	06500	RESPIRATORY THERAPY	9,062	407	2,108	0	4,348	65.00
66.00	06600	PHYSICAL THERAPY	8,329	1,969	1,699	0	2,609	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,490	572	495	0	435	67.00
68.00	06800	SPEECH PATHOLOGY	423	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	427	0	0	0	435	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,707	30	538	0	1,304	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,311	0	946	0	1,304	73.00
75.00	07500	ASC (NON-DISTINCT PART)	17,291	1,205	6,195	5,064	1,304	75.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	18,802	183	3,205	1,115	3,044	90.00
91.00	09100	EMERGENCY	20,710	6,473	7,657	2,053	7,827	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	5,023	0	903	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	255,276	32,220	68,634	173,968	66,963	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,013	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	48,767	367	21,208	0	13,915	192.00
192.01	19201	MARKETING	247	0	0	0	435	192.01
192.02	19202	FOUNDATION	243	0	0	0	435	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	305,546	32,587	89,842	173,968	81,748	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B Part II | Date/Time Prepared: 8/20/2013 3:08 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	BUSINESS OFFICE						5.01
5.02	00511	DATA PROCESSING						5.02
5.03	00512	ADMITTING						5.03
5.04	00513	PURCHASING, RECEIVING & STORES						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
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	33,892					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	106,324				16.00
17.00	01700	SOCIAL SERVICE	0	0	32,623			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,894	38,076	27,652	1,364,895	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,576	605	803	208,508	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,267	0	0	327,821	0	50.00
51.00	05100	RECOVERY ROOM	238	0	0	54,120	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,133	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,326	0	406,402	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,420	0	72,677	0	58.00
60.00	06000	LABORATORY	0	1,512	0	212,820	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,004	0	177,342	0	65.00
66.00	06600	PHYSICAL THERAPY	0	567	0	148,005	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	454	0	47,270	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	76	0	8,450	0	68.00
69.00	06900	ELECTROCARDIOLOGY	161	1,248	0	11,928	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	193,125	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	109,889	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	908	6,503	2,256	285,116	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,426	12,440	0	313,109	0	90.00
91.00	09100	EMERGENCY	6,017	16,372	1,415	448,250	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,068	0	497	101,176	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	33,555	94,603	32,623	4,504,036	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	14,697	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	337	11,721	0	782,852	0	192.00
192.01	19201	MARKETING	0	0	0	5,504	0	192.01
192.02	19202	FOUNDATION	0	0	0	7,913	0	192.02
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)	33,892	106,324	32,623	5,315,002	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B Part II | Date/Time Prepared: 8/20/2013 3:08 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.01	00510	BUSINESS OFFICE			5.01
5.02	00511	DATA PROCESSING			5.02
5.03	00512	ADMITTING			5.03
5.04	00513	PURCHASING, RECEIVING & STORES			5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL			5.05
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
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	1,364,895		30.00
31.00	03100	INTENSIVE CARE UNIT	208,508		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	327,821		50.00
51.00	05100	RECOVERY ROOM	54,120		51.00
53.00	05300	ANESTHESIOLOGY	13,133		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	406,402		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	72,677		58.00
60.00	06000	LABORATORY	212,820		60.00
65.00	06500	RESPIRATORY THERAPY	177,342		65.00
66.00	06600	PHYSICAL THERAPY	148,005		66.00
67.00	06700	OCCUPATIONAL THERAPY	47,270		67.00
68.00	06800	SPEECH PATHOLOGY	8,450		68.00
69.00	06900	ELECTROCARDIOLOGY	11,928		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	193,125		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	109,889		73.00
75.00	07500	ASC (NON-DISTINCT PART)	285,116		75.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	313,109		90.00
91.00	09100	EMERGENCY	448,250		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101,176		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,504,036		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,697		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	782,852		192.00
192.01	19201	MARKETING	5,504		192.01
192.02	19202	FOUNDATION	7,913		192.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	5,315,002		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B-1 | Date/Time Prepared: 8/20/2013 3:08 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	BUSINESS OFFICE (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	101,157					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		89,506				2.00
4.00	00400	EMPLOYEE BENEFITS	141	141	13,919,010			4.00
5.01	00510	BUSINESS OFFICE	1,330	1,330	322,265	-748,776	30,617,418	5.01
5.02	00511	DATA PROCESSING	1,553	1,553	384,364	0	979,163	5.02
5.03	00512	ADMITTING	820	820	144,757	0	236,112	5.03
5.04	00513	PURCHASING, RECEIVING & STORES	364	364	93,649	0	168,553	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	19,467	19,467	734,089	0	2,714,066	5.05
7.00	00700	OPERATION OF PLANT	4,483	4,483	428,681	0	1,431,989	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	474	474	0	0	113,804	8.00
9.00	00900	HOUSEKEEPING	1,094	1,094	366,330	0	586,296	9.00
10.00	01000	DIETARY	2,721	2,721	102,809	0	330,770	10.00
11.00	01100	CAFETERIA	1,074	1,074	200,315	0	327,916	11.00
13.00	01300	NURSING ADMINISTRATION	355	355	201,418	0	274,743	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	887	887	248,317	0	475,236	16.00
17.00	01700	SOCIAL SERVICE	299	299	204,289	0	280,551	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,277	15,277	1,865,014	0	3,476,053	30.00
31.00	03100	INTENSIVE CARE UNIT	2,314	2,314	580,987	0	985,466	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,371	4,371	470,883	0	1,172,750	50.00
51.00	05100	RECOVERY ROOM	773	773	61,895	0	164,951	51.00
53.00	05300	ANESTHESIOLOGY	129	129	0	0	103,200	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,974	4,974	538,991	0	1,921,335	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,037	1,037	65,903	0	140,824	58.00
60.00	06000	LABORATORY	1,898	1,898	744,238	0	1,868,350	60.00
65.00	06500	RESPIRATORY THERAPY	2,165	2,165	525,607	0	818,000	65.00
66.00	06600	PHYSICAL THERAPY	1,990	1,990	340,091	0	562,123	66.00
67.00	06700	OCCUPATIONAL THERAPY	595	595	97,015	0	235,302	67.00
68.00	06800	SPEECH PATHOLOGY	101	101	0	0	55,649	68.00
69.00	06900	ELECTROCARDIOLOGY	102	102	38,113	0	90,182	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,797	2,797	62,475	0	644,901	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	791	791	277,144	0	1,342,287	73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,131	4,131	170,638	0	462,997	75.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,492	4,492	302,695	0	666,341	90.00
91.00	09100	EMERGENCY	4,948	4,948	839,708	0	2,500,661	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,200	1,200	366,170	0	588,345	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	89,147	89,147	10,778,850	-748,776	25,718,916	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	242	242	0	0	13,117	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,651	0	3,078,722	0	4,755,344	192.00
192.01	19201	MARKETING	59	59	21,291	0	36,764	192.01
192.02	19202	FOUNDATION	58	58	40,147	0	93,277	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,351,587	1,885,751	3,737,494		748,776	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.132527	21.068431	0.268517		0.024456	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			7,643		72,264	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000549		0.002360	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B-1 | Date/Time Prepared: 8/20/2013 3:08 pm

		Cost Center Description	DATA PROCESSING (MACHINE HOURS)	Reconciliation	ADMITTING (ACCUM. COST)	PURCHASING, RECEIVING & STORES (COSTED REQUIS.)	Reconciliation	
			5.02	5A.03	5.03	5.04	5A.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	BUSINESS OFFICE						5.01
5.02	00511	DATA PROCESSING	600,711					5.02
5.03	00512	ADMITTING	3,812	-248,252	26,053,580			5.03
5.04	00513	PURCHASING, RECEIVING & STORES	0	0	172,675	1,275,590		5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	45,157	0	2,855,847	41,697	-2,888,758	5.05
7.00	00700	OPERATION OF PLANT	0	0	1,467,010	24,546	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	116,587	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	600,634	21,673	0	9.00
10.00	01000	DIETARY	3,174	0	344,159	4,457	0	10.00
11.00	01100	CAFETERIA	6,183	0	346,261	8,683	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,546	0	284,044	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	144,179	0	727,618	3,545	0	16.00
17.00	01700	SOCIAL SERVICE	5,542	0	296,666	1,719	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	133,626	0	3,784,201	118,822	0	30.00
31.00	03100	INTENSIVE CARE UNIT	25,261	0	1,051,750	6,298	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,897	0	1,207,938	222,455	0	50.00
51.00	05100	RECOVERY ROOM	0	0	168,985	0	0	51.00
53.00	05300	ANESTHESIOLOGY	481	0	106,527	49,240	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,182	0	2,033,752	19,292	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,676	0	157,086	3,780	0	58.00
60.00	06000	LABORATORY	5,240	0	1,922,792	430,012	0	60.00
65.00	06500	RESPIRATORY THERAPY	28,720	0	885,964	19,673	0	65.00
66.00	06600	PHYSICAL THERAPY	722	0	577,076	17,453	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	594	0	242,049	11,262	0	67.00
68.00	06800	SPEECH PATHOLOGY	312	0	57,531	449	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	92,387	10,066	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	660,673	3,583	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,308	0	1,400,676	6,548	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	353	0	474,909	15,722	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	682,637	23,403	0	90.00
91.00	09100	EMERGENCY	5,719	0	2,571,367	91,398	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	8,615	0	617,120	10,974	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	485,299	-248,252	25,906,921	1,166,750	-2,888,758	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	13,438	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	115,412	-5,064,362	0	105,583	0	192.00
192.01	19201	MARKETING	0	0	37,663	1,211	0	192.01
192.02	19202	FOUNDATION	0	0	95,558	2,046	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,003,109		248,252	174,320		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.669870		0.009529	0.136658		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	86,696		45,631	20,480		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.144322		0.001751	0.016055		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B-1 | Date/Time Prepared: 8/20/2013 3:08 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.05	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	BUSINESS OFFICE						5.01
5.02	00511	DATA PROCESSING						5.02
5.03	00512	ADMITTING						5.03
5.04	00513	PURCHASING, RECEIVING & STORES						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	28,477,436					5.05
7.00	00700	OPERATION OF PLANT	1,484,343	72,999				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	117,698	474	156,089			8.00
9.00	00900	HOUSEKEEPING	609,319	1,094	0	4,177		9.00
10.00	01000	DIETARY	348,047	2,721	0	0	16,696	10.00
11.00	01100	CAFETERIA	350,748	1,074	0	153	0	11.00
13.00	01300	NURSING ADMINISTRATION	286,751	355	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	735,035	887	0	17	0	16.00
17.00	01700	SOCIAL SERVICE	299,728	299	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,836,488	15,277	68,163	1,008	14,773	30.00
31.00	03100	INTENSIVE CARE UNIT	1,062,633	2,314	6,882	137	1,133	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,249,848	4,371	16,654	304	0	50.00
51.00	05100	RECOVERY ROOM	170,595	773	0	54	0	51.00
53.00	05300	ANESTHESIOLOGY	114,271	129	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,055,768	4,974	8,959	258	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	159,100	1,037	1,755	51	0	58.00
60.00	06000	LABORATORY	1,999,879	1,898	0	105	0	60.00
65.00	06500	RESPIRATORY THERAPY	897,094	2,165	1,950	98	0	65.00
66.00	06600	PHYSICAL THERAPY	584,960	1,990	9,432	79	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	245,894	595	2,740	23	0	67.00
68.00	06800	SPEECH PATHOLOGY	58,140	101	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	94,643	102	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	667,459	2,797	144	25	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,414,918	791	0	44	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	481,583	4,131	5,770	288	486	75.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	692,340	4,492	877	149	107	90.00
91.00	09100	EMERGENCY	2,608,360	4,948	31,006	356	197	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	624,501	1,200	0	42	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,250,143	60,989	154,332	3,191	16,696	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,566	242	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,078,791	11,651	1,757	986	0	192.00
192.01	19201	MARKETING	38,187	59	0	0	0	192.01
192.02	19202	FOUNDATION	96,749	58	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,888,758	1,634,915	140,253	695,630	444,294	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.101440	22.396403	0.898545	166.538185	26.610805	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,074,125	305,546	32,587	89,842	173,968	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.037718	4.185619	0.208772	21.508738	10.419741	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B-1 | Date/Time Prepared: 8/20/2013 3:08 pm

		Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
			11.00	13.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	BUSINESS OFFICE						5.01
5.02	00511	DATA PROCESSING						5.02
5.03	00512	ADMITTING						5.03
5.04	00513	PURCHASING, RECEIVING & STORES						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
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	188					11.00
13.00	01300	NURSING ADMINISTRATION	2	310,776				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7	0	2,812			16.00
17.00	01700	SOCIAL SERVICE	4	0	0	853		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43	154,930	1,007	723		30.00
31.00	03100	INTENSIVE CARE UNIT	9	32,788	16	21		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9	20,783	0	0		50.00
51.00	05100	RECOVERY ROOM	1	2,181	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10	0	326	0		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1	0	64	0		58.00
60.00	06000	LABORATORY	16	0	40	0		60.00
65.00	06500	RESPIRATORY THERAPY	10	0	53	0		65.00
66.00	06600	PHYSICAL THERAPY	6	0	15	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1	0	12	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	2	0		68.00
69.00	06900	ELECTROCARDIOLOGY	1	1,473	33	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3	0	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	3	8,324	172	59		75.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7	13,078	329	0		90.00
91.00	09100	EMERGENCY	18	55,172	433	37		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	18,960	0	13		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	154	307,689	2,502	853		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	32	3,087	310	0		192.00
192.01	19201	MARKETING	1	0	0	0		192.01
192.02	19202	FOUNDATION	1	0	0	0		192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	435,862	328,427	848,523	346,103		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2,318.414894	1.056797	301.750711	405.747948		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	81,748	33,892	106,324	32,623		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	434.829787	0.109056	37.810811	38.245018		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet C Part I Date/Time Prepared: 8/20/2013 3:08 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	6,050,689		6,050,689	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,350,266		1,350,266	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,582,949		1,582,949	0	0	50.00
51.00	05100	RECOVERY ROOM	218,828		218,828	0	0	51.00
53.00	05300	ANESTHESIOLOGY	128,752		128,752	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,548,277		2,548,277	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	230,164		230,164	0	0	58.00
60.00	06000	LABORATORY	2,311,907		2,311,907	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,093,833	0	1,093,833	0	0	65.00
66.00	06600	PHYSICAL THERAPY	728,935	0	728,935	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	296,394	0	296,394	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	66,904	0	66,904	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	120,361		120,361	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	809,056		809,056	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,590,446		1,590,446	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	780,628		780,628	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,020,951		1,020,951	0	0	90.00
91.00	09100	EMERGENCY	3,321,867		3,321,867	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,153,313		1,153,313		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	747,033		747,033		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	26,151,553	0	26,151,553	0	0	200.00
201.00		Less Observation Beds	1,153,313		1,153,313		0	201.00
202.00		Total (see instructions)	24,998,240	0	24,998,240	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet C Part I Date/Time Prepared: 8/20/2013 3:08 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	4,334,645		4,334,645			30.00
31.00	03100	INTENSIVE CARE UNIT	756,841		756,841			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	819,841	2,936,186	3,756,027	0.421442	0.000000	50.00
51.00	05100	RECOVERY ROOM	88,188	290,827	379,015	0.577360	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	233,477	886,182	1,119,659	0.114992	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,173,988	10,644,517	11,818,505	0.215618	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	109,384	2,170,187	2,279,571	0.100968	0.000000	58.00
60.00	06000	LABORATORY	1,543,626	8,119,957	9,663,583	0.239239	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,107,691	420,698	1,528,389	0.715677	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	377,959	1,502,513	1,880,472	0.387634	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	184,611	357,469	542,080	0.546772	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	7,696	133,105	140,801	0.475167	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	159,045	1,652,258	1,811,303	0.066450	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,150,040	1,214,805	3,364,845	0.240444	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,403,968	3,011,902	4,415,870	0.360166	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	350	584,388	584,738	1.335005	0.000000	75.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,210	413,286	415,496	2.457186	0.000000	90.00
91.00	09100	EMERGENCY	149,711	3,893,338	4,043,049	0.821624	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	42,681	824,099	866,780	1.330572	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	700,033	700,033			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	14,645,952	39,755,750	54,401,702			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,645,952	39,755,750	54,401,702			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet C Part I Date/Time Prepared: 8/20/2013 3:08 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
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
		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: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D Part II Date/Time Prepared: 8/20/2013 3:08 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	327,821	3,756,027	0.087279	454,770	39,692	50.00
51.00	05100	RECOVERY ROOM	54,120	379,015	0.142791	46,159	6,591	51.00
53.00	05300	ANESTHESIOLOGY	13,133	1,119,659	0.011729	133,223	1,563	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	406,402	11,818,505	0.034387	711,853	24,478	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	72,677	2,279,571	0.031882	70,744	2,255	58.00
60.00	06000	LABORATORY	212,820	9,663,583	0.022023	994,727	21,907	60.00
65.00	06500	RESPIRATORY THERAPY	177,342	1,528,389	0.116032	742,260	86,126	65.00
66.00	06600	PHYSICAL THERAPY	148,005	1,880,472	0.078706	103,100	8,115	66.00
67.00	06700	OCCUPATIONAL THERAPY	47,270	542,080	0.087201	38,291	3,339	67.00
68.00	06800	SPEECH PATHOLOGY	8,450	140,801	0.060014	2,660	160	68.00
69.00	06900	ELECTROCARDIOLOGY	11,928	1,811,303	0.006585	113,130	745	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	193,125	3,364,845	0.057395	1,527,109	87,648	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	109,889	4,415,870	0.024885	822,102	20,458	73.00
75.00	07500	ASC (NON-DISTINCT PART)	285,116	584,738	0.487596	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	313,109	415,496	0.753579	862	650	90.00
91.00	09100	EMERGENCY	448,250	4,043,049	0.110869	897	99	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	866,780	0.000000	0	0	92.00
200.00		Total (lines 50-199)	2,829,457	48,610,183		5,761,887	303,826	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D Part IV | Date/Time Prepared: 8/20/2013 3:08 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	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D Part IV | Date/Time Prepared: 8/20/2013 3:08 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	3,756,027	0.000000	0.000000	454,770	50.00
51.00	05100	RECOVERY ROOM	0	379,015	0.000000	0.000000	46,159	51.00
53.00	05300	ANESTHESIOLOGY	0	1,119,659	0.000000	0.000000	133,223	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,818,505	0.000000	0.000000	711,853	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,279,571	0.000000	0.000000	70,744	58.00
60.00	06000	LABORATORY	0	9,663,583	0.000000	0.000000	994,727	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,528,389	0.000000	0.000000	742,260	65.00
66.00	06600	PHYSICAL THERAPY	0	1,880,472	0.000000	0.000000	103,100	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	542,080	0.000000	0.000000	38,291	67.00
68.00	06800	SPEECH PATHOLOGY	0	140,801	0.000000	0.000000	2,660	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,811,303	0.000000	0.000000	113,130	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,364,845	0.000000	0.000000	1,527,109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,415,870	0.000000	0.000000	822,102	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	584,738	0.000000	0.000000	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	415,496	0.000000	0.000000	862	90.00
91.00	09100	EMERGENCY	0	4,043,049	0.000000	0.000000	897	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	866,780	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	48,610,183			5,761,887	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D Part IV | Date/Time Prepared: 8/20/2013 3:08 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	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D Part V Date/Time Prepared: 8/20/2013 3:08 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	0.421442	0	984,009	0	0	50.00
51.00	05100	RECOVERY ROOM	0.577360	0	96,739	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.114992	0	317,644	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.215618	0	4,480,197	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.100968	0	744,393	0	0	58.00
60.00	06000	LABORATORY	0.239239	0	3,960,621	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.715677	0	182,670	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.387634	0	594,852	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.546772	0	122,966	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.475167	0	21,278	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066450	0	810,338	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.240444	0	354,751	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.360166	0	1,796,627	16,880	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.335005	0	234,003	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.457186	0	302,470	0	0	90.00
91.00	09100	EMERGENCY	0.821624	0	1,335,963	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.330572	0	507,075	0	0	92.00
200.00		Subtotal (see instructions)		0	16,846,596	16,880	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	16,846,596	16,880	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D Part V Date/Time Prepared: 8/20/2013 3:08 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	414,703	0		50.00
51.00	05100	RECOVERY ROOM	55,853	0		51.00
53.00	05300	ANESTHESIOLOGY	36,527	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	966,011	0		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	75,160	0		58.00
60.00	06000	LABORATORY	947,535	0		60.00
65.00	06500	RESPIRATORY THERAPY	130,733	0		65.00
66.00	06600	PHYSICAL THERAPY	230,585	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	67,234	0		67.00
68.00	06800	SPEECH PATHOLOGY	10,111	0		68.00
69.00	06900	ELECTROCARDIOLOGY	53,847	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	85,298	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	647,084	6,080		73.00
75.00	07500	ASC (NON-DISTINCT PART)	312,395	0		75.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	743,225	0		90.00
91.00	09100	EMERGENCY	1,097,659	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	674,700	0		92.00
200.00		Subtotal (see instructions)	6,548,660	6,080		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	6,548,660	6,080		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141310 | Component CCN: 14Z310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D Part V | Date/Time Prepared: 8/20/2013 3:08 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	0.421442	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.577360	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.114992	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.215618	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.100968	0	0	0	0	58.00
60.00	06000	LABORATORY	0.239239	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.715677	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.387634	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.546772	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.475167	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066450	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.240444	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.360166	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.335005	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.457186	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.821624	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.330572	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: 141310 | Component CCN: 14Z310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D Part V | Date/Time Prepared: 8/20/2013 3:08 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
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	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: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D-1 | Date/Time Prepared: 8/20/2013 3:08 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)	4,617	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,355	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)	2,493	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	839	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)	319	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	87	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)	17	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,968	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)	839	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)	279	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	120.63	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	120.63	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,050,689	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)	10,495	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	2,051	25.00
26.00	Total swing-bed cost (see instructions)	1,561,881	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,488,808	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	5,201,425	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	5,201,425	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.862996	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)	2,086.41	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)	4,488,808	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)	1,337.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,633,066	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,633,066	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D-1 | Date/Time Prepared: 8/20/2013 3:08 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	1,350,266	346	3,902.50	260	1,014,650	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,899,269	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,546,985	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)	1,122,532	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	373,285	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,495,817	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)	862	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,337.95	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,153,313	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D-1 | Date/Time Prepared: 8/20/2013 3:08 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: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D-3 | Date/Time Prepared: 8/20/2013 3:08 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		2,299,707		30.00
31.00	03100	INTENSIVE CARE UNIT		528,176		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.421442	454,770	191,659	50.00
51.00	05100	RECOVERY ROOM	0.577360	46,159	26,650	51.00
53.00	05300	ANESTHESIOLOGY	0.114992	133,223	15,320	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.215618	711,853	153,488	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.100968	70,744	7,143	58.00
60.00	06000	LABORATORY	0.239239	994,727	237,977	60.00
65.00	06500	RESPIRATORY THERAPY	0.715677	742,260	531,218	65.00
66.00	06600	PHYSICAL THERAPY	0.387634	103,100	39,965	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.546772	38,291	20,936	67.00
68.00	06800	SPEECH PATHOLOGY	0.475167	2,660	1,264	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066450	113,130	7,517	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.240444	1,527,109	367,184	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.360166	822,102	296,093	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.335005	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.457186	862	2,118	90.00
91.00	09100	EMERGENCY	0.821624	897	737	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.330572	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		5,761,887	1,899,269	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		5,761,887		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141310 | Component CCN: 14Z310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D-3 | Date/Time Prepared: 8/20/2013 3:08 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	0.421442	42,836	18,053	50.00
51.00	05100	RECOVERY ROOM	0.577360	193	111	51.00
53.00	05300	ANESTHESIOLOGY	0.114992	6,059	697	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.215618	97,970	21,124	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.100968	0	0	58.00
60.00	06000	LABORATORY	0.239239	206,216	49,335	60.00
65.00	06500	RESPIRATORY THERAPY	0.715677	204,172	146,121	65.00
66.00	06600	PHYSICAL THERAPY	0.387634	225,893	87,564	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.546772	124,350	67,991	67.00
68.00	06800	SPEECH PATHOLOGY	0.475167	4,868	2,313	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066450	14,207	944	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.240444	290,723	69,903	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.360166	173,885	62,627	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.335005	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.457186	0	0	90.00
91.00	09100	EMERGENCY	0.821624	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.330572	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,391,372	526,783	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,391,372		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141310	Period: From 04/01/2012 To 03/31/2013	Worksheet E Part B Date/Time Prepared: 8/20/2013 3:08 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,554,740	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)	6,554,740	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)	6,620,287	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	35,491	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,557,948	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	4,026,848	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	4,026,848	30.00
31.00	Primary payer payments	2,058	31.00
32.00	Subtotal (line 30 minus line 31)	4,024,790	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)	461,980	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	461,980	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	423,432	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	4,486,770	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	AB Re-billing demo amount (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	4,486,770	40.00
41.00	Interim payments	4,039,131	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)	447,639	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: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 8/20/2013 3:08 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		5,196,737		3,867,138	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	09/07/2012	92,455	09/07/2012	134,607	3.01
3.02		03/08/2013	54,040	03/08/2013	37,386	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)		146,495		171,993	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)		5,343,232		4,039,131	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		447,639	6.01
6.02	SETTLEMENT TO PROGRAM		111,588		0	6.02
7.00	Total Medicare program liability (see instructions)		5,231,644		4,486,770	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141310 | Component CCN: 14Z310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 8/20/2013 3:08 pm

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		1,995,270		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	09/07/2012	17,781		0	3.01
3.02		03/08/2013	7,759		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)		25,540		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,020,810		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		1,582		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,022,392		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 141310 | Component CCN: 14Z310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet E-2 | Date/Time Prepared: 8/20/2013 3:08 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)	1,510,775	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)	532,051	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	1,118	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)	2,042,826	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,042,826	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)	2,042,826	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	20,434	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)	2,022,392	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	2,022,392	0	19.00
20.00	Interim payments	2,020,810	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)	1,582	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: 141310	Period: From 04/01/2012 To 03/31/2013	Worksheet E-3 Part V Date/Time Prepared: 8/20/2013 3:08 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	5,546,985	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)	5,546,985	4.00
5.00	Primary payer payments	9,644	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,592,811	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)	5,592,811	19.00
20.00	Deductibles (exclude professional component)	440,578	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	5,152,233	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	5,152,233	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	79,411	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	79,411	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	70,760	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,231,644	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	5,231,644	30.00
31.00	Interim payments	5,343,232	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)	-111,588	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: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet G | Date/Time Prepared: 8/20/2013 3:08 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	544,005	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,174,778	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,476,000	0	0	0	6.00
7.00	Inventory	705,529	0	0	0	7.00
8.00	Prepaid expenses	678,984	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,627,296	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,272,124	0	0	0	12.00
13.00	Land improvements	4,977,101	0	0	0	13.00
14.00	Accumulated depreciation	-520,080	0	0	0	14.00
15.00	Buildings	30,855,360	0	0	0	15.00
16.00	Accumulated depreciation	-3,068,285	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	4,255,580	0	0	0	19.00
20.00	Accumulated depreciation	-1,044,304	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	10,528,579	0	0	0	23.00
24.00	Accumulated depreciation	-6,871,987	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	40,384,088	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,797,903	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,797,903	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	50,809,287	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	661,772	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,151,168	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,189,901	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	460,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,462,841	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	34,649,449	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	34,649,449	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	40,112,290	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	10,696,997				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)	10,696,997	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	50,809,287	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet G-1 | Date/Time Prepared: 8/20/2013 3:08 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		14,329,870		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,676,534				2.00
3.00	Total (sum of line 1 and line 2)		11,653,336		0		3.00
4.00	INCREASE IN RESTRICTED FUNDS	44		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)		44		0		10.00
11.00	Subtotal (line 3 plus line 10)		11,653,380		0		11.00
12.00	UNREALIZED LOSSES ON SECURITIES	956,383		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)		956,383		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,696,997		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	INCREASE IN RESTRICTED FUNDS		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	UNREALIZED LOSSES ON SECURITIES		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: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/20/2013 3:08 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,245,539		3,245,539	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	999,354		999,354	5.00
6.00	Swing bed - NF	89,752		89,752	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)	4,334,645		4,334,645	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	756,841		756,841	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)	756,841		756,841	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,091,486		5,091,486	17.00
18.00	Ancillary services	9,359,864	33,924,994	43,284,858	18.00
19.00	Outpatient services	194,602	5,130,723	5,325,325	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		700,033	700,033	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	351,727	9,474,534	9,826,261	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	14,997,679	49,230,284	64,227,963	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		34,640,253		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)		34,640,253		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet G-3 | Date/Time Prepared: 8/20/2013 3:08 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	64,227,963	1.00
2.00	Less contractual allowances and discounts on patients' accounts	34,667,439	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,560,524	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	34,640,253	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,079,729	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	148,460	6.00
7.00	Income from investments	1,137,963	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	462	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	72,495	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	11,605	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	9,147	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	1,834	21.00
22.00	Rental of hospital space	92,504	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANT INCOME	385,088	24.00
24.01	MEALS ON WHEELS INCOME	25,629	24.01
24.02	EHR MEANINGFUL USE INCOME	126,000	24.02
24.03	MEDICAID ADD ON PAYMENTS	142,895	24.03
24.04	FARM INCOME	32,920	24.04
24.05	HPSA & OTHER PHYSICIAN INCOME	196,499	24.05
24.06	MISCELLANEOUS INCOME	19,814	24.06
25.00	Total other income (sum of lines 6-24)	2,403,315	25.00
26.00	Total (line 5 plus line 25)	-2,676,414	26.00
27.00	LOSS ON DISPOSAL OF ASSETS	120	27.00
27.01		0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	120	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,676,534	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141310 | HHA CCN: 147616 | Period: From 04/01/2012 To 03/31/2013 | Worksheet H | Date/Time Prepared: 8/20/2013 3:08 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		14,429	14,429	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	23,654	0	0	23,654	4.00
5.00	Administrative and General	112,975	0	0	0	34,952	147,927	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	229,981	0	0	0	0	229,981	6.00
7.00	Physical Therapy	0	0	0	8,515	0	8,515	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	708	0	708	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	4,701	0	0	0	0	4,701	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	517	517	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	347,657	0	23,654	9,223	49,898	430,432	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	-14,429	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	23,654	0	23,654			4.00
5.00	Administrative and General	-9,535	138,392	0	138,392			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	229,981	0	229,981			6.00
7.00	Physical Therapy	14,386	22,901	0	22,901			7.00
8.00	Occupational Therapy	4,127	4,127	0	4,127			8.00
9.00	Speech Pathology	0	708	0	708			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	4,701	0	4,701			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	517	0	517			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	-5,451	424,981	0	424,981			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 141310 HHA CCN: 147616

Period: From 04/01/2012 To 03/31/2013

Worksheet H-1 Part I Date/Time Prepared: 8/20/2013 3:08 pm

Home Health Agency I

PPS

			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	23,654	0	0	0	23,654		4.00
5.00	Administrative and General	138,392	0	0	0	23,654	162,046	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	229,981	0	0	0	0	229,981	6.00
7.00	Physical Therapy	22,901	0	0	0	0	22,901	7.00
8.00	Occupational Therapy	4,127	0	0	0	0	4,127	8.00
9.00	Speech Pathology	708	0	0	0	0	708	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	4,701	0	0	0	0	4,701	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	517	0	0	0		517	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	424,981	0	0	0	23,654	424,981	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	162,046		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	141,737	371,718	6.00
7.00	Physical Therapy	14,114	37,015	7.00
8.00	Occupational Therapy	2,543	6,670	8.00
9.00	Speech Pathology	436	1,144	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	2,897	7,598	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	319	836	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		424,981	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 141310 | HHA CCN: 147616 | Period: From 04/01/2012 To 03/31/2013 | Worksheet H-1 Part II | Date/Time Prepared: 8/20/2013 3:08 pm

Home Health Agency I | PPS

		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	23,654			4.00
5.00	Administrative and General	0	0	0	23,654	-162,046	262,935	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	229,981	6.00
7.00	Physical Therapy	0	0	0	0	0	22,901	7.00
8.00	Occupational Therapy	0	0	0	0	0	4,127	8.00
9.00	Speech Pathology	0	0	0	0	0	708	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	4,701	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	517	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	23,654	-162,046	262,935	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	23,654		162,046	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	1.000000		0.616297	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet H-2 Part I | Date/Time Prepared: 8/20/2013 3:08 pm

HHA CCN: 147616 | Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	BUSINESS OFFICE	
		0	1.00	2.00	4.00	4A	5.01	
1.00	Administrative and General	0	39,759	25,282	30,336	95,377	2,333	1.00
2.00	Skilled Nursing Care	371,718	0	0	61,754	433,472	10,601	2.00
3.00	Physical Therapy	37,015	0	0	3,863	40,878	1,000	3.00
4.00	Occupational Therapy	6,670	0	0	1,108	7,778	190	4.00
5.00	Speech Pathology	1,144	0	0	0	1,144	28	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	7,598	0	0	1,262	8,860	217	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	836	0	0	0	836	20	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	424,981	39,759	25,282	98,323	588,345	14,389	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	DATA PROCESSING	Subtotal	ADMITTING	PURCHASING, RECEIVING & STORES	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
		5.02	5A.02	5.03	5.04	5A.04	5.05	
1.00	Administrative and General	14,386	112,096	1,068	1,500	114,664	11,631	1.00
2.00	Skilled Nursing Care	0	444,073	4,232	0	448,305	45,475	2.00
3.00	Physical Therapy	0	41,878	399	0	42,277	4,289	3.00
4.00	Occupational Therapy	0	7,968	76	0	8,044	816	4.00
5.00	Speech Pathology	0	1,172	11	0	1,183	120	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	9,077	87	0	9,164	930	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	856	8	0	864	88	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	14,386	617,120	5,881	1,500	624,501	63,349	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.000000			0.000000		21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141310 | HHA CCN: 147616 | Period: From 04/01/2012 To 03/31/2013 | Worksheet H-2 Part I | Date/Time Prepared: 8/20/2013 3:08 pm

Home Health Agency I | PPS

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	26,876	0	6,995	0	0	20,037	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	26,876	0	6,995	0	0	20,037	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		16.00	17.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	0	180,203	0	180,203		1.00
2.00	Skilled Nursing Care	0	0	493,780	0	493,780	156,979	2.00
3.00	Physical Therapy	0	0	46,566	0	46,566	14,804	3.00
4.00	Occupational Therapy	0	0	8,860	0	8,860	2,817	4.00
5.00	Speech Pathology	0	0	1,303	0	1,303	414	5.00
6.00	Medical Social Services	0	5,275	5,275	0	5,275	1,677	6.00
7.00	Home Health Aide	0	0	10,094	0	10,094	3,209	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	952	0	952	303	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	5,275	747,033	0	747,033	180,203	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.317914	21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141310 | HHA CCN: 147616 | Period: From 04/01/2012 To 03/31/2013 | Worksheet H-2 Part I | Date/Time Prepared: 8/20/2013 3:08 pm

Home Health Agency I | PPS

	Cost Center Description	Total HHA Costs				
		28.00				
1.00	Administrative and General					1.00
2.00	Skilled Nursing Care	650,759				2.00
3.00	Physical Therapy	61,370				3.00
4.00	Occupational Therapy	11,677				4.00
5.00	Speech Pathology	1,717				5.00
6.00	Medical Social Services	6,952				6.00
7.00	Home Health Aide	13,303				7.00
8.00	Supplies (see instructions)	0				8.00
9.00	Drugs	1,255				9.00
10.00	DME	0				10.00
11.00	Home Dialysis Aide Services	0				11.00
12.00	Respiratory Therapy	0				12.00
13.00	Private Duty Nursing	0				13.00
14.00	Clinic	0				14.00
15.00	Health Promotion Activities	0				15.00
16.00	Day Care Program	0				16.00
17.00	Home Delivered Meals Program	0				17.00
18.00	Homemaker Service	0				18.00
19.00	All Others (specify)	0				19.00
20.00	Total (sum of lines 1-19) (2)	747,033				20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141310 HHA CCN: 147616 | Period: From 04/01/2012 To 03/31/2013 | Worksheet H-2 Part II Date/Time Prepared: 8/20/2013 3:08 pm

Home Health Agency I | PPS

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	BUSINESS OFFICE (ACCUM. COST)	DATA PROCESSING (MACHINE HOURS)	
		1.00	2.00	4.00	5A.01	5.01	5.02	
1.00	Administrative and General	1,200	1,200	112,975	0	95,377	8,615	1.00
2.00	Skilled Nursing Care	0	0	229,981	0	433,472	0	2.00
3.00	Physical Therapy	0	0	14,386	0	40,878	0	3.00
4.00	Occupational Therapy	0	0	4,127	0	7,778	0	4.00
5.00	Speech Pathology	0	0	0	0	1,144	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	4,701	0	8,860	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	836	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,200	1,200	366,170		588,345	8,615	20.00
21.00	Total cost to be allocated	39,759	25,282	98,323		14,389	14,386	21.00
22.00	Unit cost multiplier	33.132500	21.068333	0.268517		0.024457	1.669878	22.00

	Cost Center Description	Reconciliation	ADMITTING (ACCUM. COST)	PURCHASING, RECEIVING & STORES (COSTED REQUIS.)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5A.03	5.03	5.04	5A.05	5.05	7.00	
1.00	Administrative and General	0	112,096	10,974	0	114,664	1,200	1.00
2.00	Skilled Nursing Care	0	444,073	0	0	448,305	0	2.00
3.00	Physical Therapy	0	41,878	0	0	42,277	0	3.00
4.00	Occupational Therapy	0	7,968	0	0	8,044	0	4.00
5.00	Speech Pathology	0	1,172	0	0	1,183	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	9,077	0	0	9,164	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	856	0	0	864	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)		617,120	10,974		624,501	1,200	20.00
21.00	Total cost to be allocated		5,881	1,500		63,349	26,876	21.00
22.00	Unit cost multiplier		0.009530	0.136687		0.101439	22.396667	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141310 HHA CCN: 147616

Period: From 04/01/2012 To 03/31/2013

Worksheet H-2 Part II Date/Time Prepared: 8/20/2013 3:08 pm

Home Health Agency I

PPS

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		8.00	9.00	10.00	11.00	13.00	16.00	
1.00	Administrative and General	0	42	0	0	18,960	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	42	0	0	18,960	0	20.00
21.00	Total cost to be allocated	0	6,995	0	0	20,037	0	21.00
22.00	Unit cost multiplier	0.000000	166.547619	0.000000	0.000000	1.056804	0.000000	22.00

	Cost Center Description	SOCIAL SERVICE (TIME SPENT)	
		17.00	
1.00	Administrative and General	0	1.00
2.00	Skilled Nursing Care	0	2.00
3.00	Physical Therapy	0	3.00
4.00	Occupational Therapy	0	4.00
5.00	Speech Pathology	0	5.00
6.00	Medical Social Services	13	6.00
7.00	Home Health Aide	0	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
20.00	Total (sum of lines 1-19)	13	20.00
21.00	Total cost to be allocated	5,275	21.00
22.00	Unit cost multiplier	405.769231	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141310 | HHA CCN: 147616 | Period: From 04/01/2012 To 03/31/2013 | Worksheet H-3 Part I | Date/Time Prepared: 8/20/2013 3:08 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	650,759		650,759	1,987	327.51	1.00
2.00	Physical Therapy	3.00	61,370	0	61,370	534	114.93	2.00
3.00	Occupational Therapy	4.00	11,677	0	11,677	86	135.78	3.00
4.00	Speech Pathology	5.00	1,717	0	1,717	12	143.08	4.00
5.00	Medical Social Services	6.00	6,952		6,952	16	434.50	5.00
6.00	Home Health Aide	7.00	13,303		13,303	319	41.70	6.00
7.00	Total (sum of lines 1-6)		745,778	0	745,778	2,954		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	1,020	542			8.00
9.00	Physical Therapy		99914	253	115			9.00
10.00	Occupational Therapy		99914	45	16			10.00
11.00	Speech Pathology		99914	7	5			11.00
12.00	Medical Social Services		99914	11	9			12.00
13.00	Home Health Aide		99914	108	171			13.00
14.00	Total (sum of lines 8-13)			1,444	858			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	11,010	11,010	45,789	0.240451	15.00
16.00	Cost of Drugs	9.00	1,255	0	1,255	508	2.470472	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	1,020	542		334,060	177,510		1.00
2.00	Physical Therapy	253	115		29,077	13,217		2.00
3.00	Occupational Therapy	45	16		6,110	2,172		3.00
4.00	Speech Pathology	7	5		1,002	715		4.00
5.00	Medical Social Services	11	9		4,780	3,911		5.00
6.00	Home Health Aide	108	171		4,504	7,131		6.00
7.00	Total (sum of lines 1-6)	1,444	858		379,533	204,656		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 141310 HHA CCN: 147616 | Period: From 04/01/2012 To 03/31/2013 | Worksheet H-3 Part I Date/Time Prepared: 8/20/2013 3:08 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies							15.00
16.00	Cost of Drugs		454	0		1,122	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	511,570		1.00
2.00	Physical Therapy	42,294		2.00
3.00	Occupational Therapy	8,282		3.00
4.00	Speech Pathology	1,717		4.00
5.00	Medical Social Services	8,691		5.00
6.00	Home Health Aide	11,635		6.00
7.00	Total (sum of lines 1-6)	584,189		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141310 HHA CCN: 147616 | Period: From 04/01/2012 To 03/31/2013 | Worksheet H-3 Part II Date/Time Prepared: 8/20/2013 3:08 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.387634	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.546772	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.475167	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.240444	45,789	11,010	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.360166	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet H-4 Part I-II
HHA CCN: 147616 | Date/Time Prepared: 8/20/2013 3:08 pm

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	1,122	0	1.00
2.00	Total charges	0	454	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	454	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	668	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	1,122	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	245,819	131,112	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	1,308	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	9,229	4,266	13.00
14.00	Total PPS Reimbursement - PEP Episodes	1,840	601	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	152	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	256,888	138,561	22.00
23.00	Excess reasonable cost (from line 8)	0	668	23.00
24.00	Subtotal (line 22 minus line 23)	256,888	137,893	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	256,888	137,893	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 141310
HHA CCN: 147616

Period:
From 04/01/2012
To 03/31/2013

Worksheet H-4
Part I-II
Date/Time Prepared:
8/20/2013 3:08 pm

Title XVIII | Home Health Agency I | PPS

		Part A Services	Part B Services	
		1.00	2.00	
29.00	Total costs - current cost reporting period (line 26 plus line 27)	256,888	137,893	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	256,888	137,893	31.00
32.00	Interim payments (see instructions)	256,888	137,893	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	35.00

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

Provider CCN: 141310 | Period: From 04/01/2012 To 03/31/2013 | Worksheet H-5
HHA CCN: 147616 | Date/Time Prepared: 8/20/2013 3:08 pm
Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		256,888		137,893	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		256,888		137,893	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		256,888		137,893	7.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141310 HHA CCN: 147616	Period: From 04/01/2012 To 03/31/2013	Worksheet H-5 Date/Time Prepared: 8/20/2013 3:08 pm
		Home Health Agency I	PPS

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