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: 141312	Period: From 05/01/2012 To 04/30/2013	Worksheet S Parts I-III Date/Time Prepared: 8/20/2013 9:42 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 8/20/2013 Time: 9:42 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ROCHELLE COMMUNITY HOSPITAL (141312) for the cost reporting period beginning 05/01/2012 and ending 04/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	80,389	-89,665	186,046	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	-12,208	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	68,181	-89,665	186,046	0	200.00

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

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: 141312	Period: From 05/01/2012 To 04/30/2013	Worksheet S Parts I-III Date/Time Prepared: 8/20/2013 9:42 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 8/20/2013 Time: 9:42 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ROCHELLE COMMUNITY HOSPITAL (141312) for the cost reporting period beginning 05/01/2012 and ending 04/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 8/20/2013 Time: 9:42 am
8I0eXGILaQfrShVuXu5A3akE3x4sp0
SvBNT0zIUPth:dc2Cjv.nCAbvjlQtH
.DZW0dCgJv0X6qW.

PI: Date: 8/20/2013 Time: 9:42 am
94IqX2ByYBOpM17nj4pz5Ze1dTnl30
kShJp0Nrbr9gLzk2iz4X09W2iyky6f
tL6r0Z7iA40r7LYC

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

_____
Title

_____
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	80,389	-89,665	186,046	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	-12,208	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	68,181	-89,665	186,046	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 8/19/2013 4:34 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 900 NORTH 2ND STREET	PO Box:			1.00
2.00	City: ROCHELLE	State: IL	Zip Code: 61068	County: OGLE	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	ROCHELLE COMMUNITY HOSPITAL	141312	99914	1	05/01/2001	N	O	O	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	ROCHELLE COMMUNITY HOSPITAL	14Z312	99914		04/17/1987	N	N	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part I Date/Time Prepared: 8/19/2013 4:34 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		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: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part I Date/Time Prepared: 8/19/2013 4:34 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: 141312	Period: From 05/01/2012 To 04/30/2013	Worksheet S-2 Part I Date/Time Prepared: 8/19/2013 4:34 pm

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	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	N	Y	109.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 8/19/2013 4:34 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	146,421	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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.	Y	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.	Y	03/27/2013	146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	Y		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	Y		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: 141312	Period: From 05/01/2012 To 04/30/2013	Worksheet S-2 Part I Date/Time Prepared: 8/19/2013 4:34 pm

							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						3,357,757	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: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 8/19/2013 4:34 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)		N		N	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)		Y	08/19/2013	Y	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: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part II Date/Time Prepared: 8/19/2013 4:34 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.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				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.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DANIEL	LARSEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	507-434-7055	DAN.LARSEN@CLIFTONLARSONALLEN.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 8/19/2013 4:34 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)				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)	08/19/2013			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.		PARTNER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-3 Part I Date/Time Prepared: 8/19/2013 4:34 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	12	4,380	41,706.00	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)		12	4,380	41,706.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		16	5,840	41,706.00	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						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)		16				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: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 8/19/2013 4:34 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)	1,066	149	1,743			1.00
2.00	HMO	155	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	95	0	106			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,161	149	1,849			7.00
8.00	INTENSIVE CARE UNIT	17	3	37			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)	1,178	152	1,886	0.00	182.62	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						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	182.62	27.00
28.00	Observation Bed Days		0	430			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: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 8/19/2013 4:34 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	359	54	628	1.00
2.00	HMO			42			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	359	54	628	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-10 | Date/Time Prepared: 8/19/2013 4:34 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)	0.491208	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,030,141	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	6,485,250	6.00
7.00	Medicaid cost (line 1 times line 6)	3,185,607	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)	1,155,466	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	188,504	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,155,466	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	1,614,616	117,283	1,731,899	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	793,112	57,610	850,722	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	793,112	57,610	850,722	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)	2,455,227	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	492,277	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	1,962,950	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	964,217	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,814,939	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,970,405	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A | Date/Time Prepared: 8/19/2013 4:34 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		658,393	658,393	270,122	928,515	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,639,380	1,639,380	81,080	1,720,460	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	260,803	3,301,801	3,562,604	0	3,562,604	4.00
5.01	00540	ADMISSIONS	300,974	16,400	317,374	49,893	367,267	5.01
5.02	00560	BUSINESS SERVICES	330,425	368,263	698,688	0	698,688	5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL	870,993	1,998,317	2,869,310	-3,067	2,866,243	5.03
7.00	00700	OPERATION OF PLANT	327,346	928,666	1,256,012	0	1,256,012	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	88,925	88,925	0	88,925	8.00
9.00	00900	HOUSEKEEPING	239,601	41,677	281,278	0	281,278	9.00
10.00	01000	DIETARY	259,067	210,192	469,259	-311,660	157,599	10.00
11.00	01100	CAFETERIA	0	0	0	311,660	311,660	11.00
13.00	01300	NURSING ADMINISTRATION	282,325	39,769	322,094	0	322,094	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	81,796	15,619	97,415	0	97,415	14.00
15.00	01500	PHARMACY	241,182	1,105,273	1,346,455	0	1,346,455	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	322,936	170,474	493,410	0	493,410	16.00
17.00	01700	SOCIAL SERVICE	185,518	10,481	195,999	0	195,999	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,625,825	164,639	1,790,464	528	1,790,992	30.00
31.00	03100	INTENSIVE CARE UNIT	20,667	13,965	34,632	0	34,632	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	698,527	804,985	1,503,512	-428,693	1,074,819	50.00
53.00	05300	ANESTHESIOLOGY	0	246,520	246,520	0	246,520	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	589,292	1,260,885	1,850,177	6,770	1,856,947	54.00
60.00	06000	LABORATORY	707,431	924,389	1,631,820	1,267	1,633,087	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	66,055	66,055	0	66,055	62.00
64.00	06400	INTRAVENOUS THERAPY	178,965	16,585	195,550	84	195,634	64.00
65.00	06500	RESPIRATORY THERAPY	21,666	918,789	940,455	-490	939,965	65.00
66.00	06600	PHYSICAL THERAPY	9,554	789,240	798,794	0	798,794	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,934	8,934	0	8,934	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	428,729	428,729	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	20,265	2,375	22,640	0	22,640	90.01
91.00	09100	EMERGENCY	1,118,164	1,642,674	2,760,838	-751	2,760,087	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		320,020	320,020	-320,020	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,693,322	17,773,685	26,467,007	85,452	26,552,459	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	248,558	139,191	387,749	0	387,749	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	371,601	66,379	437,980	-85,452	352,528	194.02
194.03	07953	ASHTON CLINIC	137,857	37,265	175,122	0	175,122	194.03
200.00		TOTAL (SUM OF LINES 118-199)	9,451,338	18,016,520	27,467,858	0	27,467,858	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A | Date/Time Prepared: 8/19/2013 4:34 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	-124,468	804,047		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-807,248	913,212		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS	-1,515	3,561,089		4.00
5.01	00540	ADMISSIONS	0	367,267		5.01
5.02	00560	BUSINESS SERVICES	0	698,688		5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL	-433,358	2,432,885		5.03
7.00	00700	OPERATION OF PLANT	-1,825	1,254,187		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	88,925		8.00
9.00	00900	HOUSEKEEPING	0	281,278		9.00
10.00	01000	DIETARY	0	157,599		10.00
11.00	01100	CAFETERIA	-128,727	182,933		11.00
13.00	01300	NURSING ADMINISTRATION	0	322,094		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	97,415		14.00
15.00	01500	PHARMACY	-44,767	1,301,688		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-11,435	481,975		16.00
17.00	01700	SOCIAL SERVICE	0	195,999		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,790,992		30.00
31.00	03100	INTENSIVE CARE UNIT	0	34,632		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,074,819		50.00
53.00	05300	ANESTHESIOLOGY	-242,645	3,875		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,856,947		54.00
60.00	06000	LABORATORY	0	1,633,087		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	66,055		62.00
64.00	06400	INTRAVENOUS THERAPY	0	195,634		64.00
65.00	06500	RESPIRATORY THERAPY	-117,827	822,138		65.00
66.00	06600	PHYSICAL THERAPY	-470	798,324		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,934		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	428,729		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC	0	22,640		90.01
91.00	09100	EMERGENCY	-811,778	1,948,309		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,726,063	23,826,396		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OCCUPATIONAL HEALTH	0	387,749		194.00
194.01	07951	FOUNDATION	0	0		194.01
194.02	07952	PHYSICIANS CLINICS	0	352,528		194.02
194.03	07953	ASHTON CLINIC	0	175,122		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-2,726,063	24,741,795		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet Non-CMS W | Date/Time Prepared: 8/19/2013 4:34 pm

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS	00400		4.00
5.01	ADMISSIONS	00540		5.01
5.02	BUSINESS SERVICES	00560		5.02
5.03	OTHER ADMINISTRATIVE AND GENERAL	00561		5.03
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	06200		62.00
64.00	INTRAVENOUS THERAPY	06400		64.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	09000		90.00
90.01	CLINIC	09001		90.01
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
194.00	OCCUPATIONAL HEALTH	07950		194.00
194.01	FOUNDATION	07951		194.01
194.02	PHYSICIANS CLINICS	07952		194.02
194.03	ASHTON CLINIC	07953		194.03
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-6 | Date/Time Prepared: 8/19/2013 4:34 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	39,152		1.00
	TOTALS		0	39,152		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	172,060	139,600		1.00
	TOTALS		172,060	139,600		
	C - NURSING-RECEPTIONIST RECLASS					
1.00	ADMISSIONS	5.01	49,893	0		1.00
2.00	RESPIRATORY THERAPY	65.00	35,559	0		2.00
	TOTALS		85,452	0		
	D - IV PUMP INTEREST					
1.00	ADULTS & PEDIATRICS	30.00	0	528		1.00
2.00	EMERGENCY	91.00	0	516		2.00
3.00	INTRAVENOUS THERAPY	64.00	0	84		3.00
4.00	OPERATING ROOM	50.00	0	36		4.00
5.00	RESPIRATORY THERAPY	65.00	0	36		5.00
	TOTALS		0	1,200		
	E - FITNESS CENTER					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	36,085		1.00
	TOTALS		0	36,085		
	F - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	230,970		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	81,080		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,770		3.00
	TOTALS		0	318,820		
	G - EKG'S					
1.00	LABORATORY	60.00	1,267	0		1.00
	TOTALS		1,267	0		
	H - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	428,729		1.00
	TOTALS		0	428,729		
500.00	Grand Total: Increases		258,779	963,586		500.00

RECLASSIFICATIONS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-6 | Date/Time Prepared: 8/19/2013 4:34 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PROPERTY INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	39,152	12		1.00
	TOTALS		0	39,152			
	B - CAFETERIA						
1.00	DIETARY	10.00	172,060	139,600	0		1.00
	TOTALS		172,060	139,600			
	C - NURSING-RECEPTIONIST RECLASS						
1.00	PHYSICIANS CLINICS	194.02	85,452	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		85,452	0			
	D - IV PUMP INTEREST						
1.00	INTEREST EXPENSE	113.00	0	1,200	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
4.00		0.00	0	0	11		4.00
5.00		0.00	0	0	11		5.00
	TOTALS		0	1,200			
	E - FITNESS CENTER						
1.00	RESPIRATORY THERAPY	65.00	0	36,085	0		1.00
	TOTALS		0	36,085			
	F - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	318,820	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	318,820			
	G - EKG'S						
1.00	EMERGENCY	91.00	1,267	0	0		1.00
	TOTALS		1,267	0			
	H - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	428,729	0		1.00
	TOTALS		0	428,729			
500.00	Grand Total: Decreases		258,779	963,586			500.00

RECLASSIFICATIONS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 8/19/2013 4:34 pm

	Increases			Decreases			
	Cost Center	Line #	Salary	Cost Center	Line #	Salary	
	2.00	3.00	4.00	6.00	7.00	8.00	
	A - PROPERTY INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	1.00
	TOTALS		0	TOTALS		0	
	B - CAFETERIA						
1.00	CAFETERIA	11.00	172,060	DIETARY	10.00	172,060	1.00
	TOTALS		172,060	TOTALS		172,060	
	C - NURSING-RECEPTIONIST RECLASS						
1.00	ADMISSIONS	5.01	49,893	PHYSICIANS CLINICS	194.02	85,452	1.00
2.00	RESPIRATORY THERAPY	65.00	35,559		0.00	0	2.00
	TOTALS		85,452	TOTALS		85,452	
	D - IV PUMP INTEREST						
1.00	ADULTS & PEDIATRICS	30.00	0	INTEREST EXPENSE	113.00	0	1.00
2.00	EMERGENCY	91.00	0		0.00	0	2.00
3.00	INTRAVENOUS THERAPY	64.00	0		0.00	0	3.00
4.00	OPERATING ROOM	50.00	0		0.00	0	4.00
5.00	RESPIRATORY THERAPY	65.00	0		0.00	0	5.00
	TOTALS		0	TOTALS		0	
	E - FITNESS CENTER						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	RESPIRATORY THERAPY	65.00	0	1.00
	TOTALS		0	TOTALS		0	
	F - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	INTEREST EXPENSE	113.00	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0		0.00	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0		0.00	0	3.00
	TOTALS		0	TOTALS		0	
	G - EKG'S						
1.00	LABORATORY	60.00	1,267	EMERGENCY	91.00	1,267	1.00
	TOTALS		1,267	TOTALS		1,267	
	H - IMPLANTABLE DEVICES						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	OPERATING ROOM	50.00	0	1.00
	TOTALS		0	TOTALS		0	
500.00	Grand Total: Increases		258,779	Grand Total: Decreases		258,779	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-7 Part I | Date/Time Prepared: 8/19/2013 4:34 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	2,976,289	0	0	0	0	1.00
2.00	Land Improvements	1,154,439	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,241,878	407,090	0	407,090	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	690,994	369,017	0	369,017	0	5.00
6.00	Movable Equipment	7,492,306	779,873	0	779,873	257,614	6.00
7.00	HIT designated Assets	0	3,424,390	0	3,424,390	0	7.00
8.00	Subtotal (sum of lines 1-7)	23,555,906	4,980,370	0	4,980,370	257,614	8.00
9.00	Reconciling Items	3,413,227	245,215	0	245,215	3,457,171	9.00
10.00	Total (line 8 minus line 9)	20,142,679	4,735,155	0	4,735,155	-3,199,557	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,976,289	0	1.00
2.00	Land Improvements	1,154,439	0	2.00
3.00	Buildings and Fixtures	11,648,968	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	1,060,011	0	5.00
6.00	Movable Equipment	8,014,565	0	6.00
7.00	HIT designated Assets	3,424,390	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,278,662	0	8.00
9.00	Reconciling Items	201,271	0	9.00
10.00	Total (line 8 minus line 9)	28,077,391	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-7 Part II | Date/Time Prepared: 8/19/2013 4:34 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	658,393	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,639,380	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,297,773	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	658,393		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,639,380		2.00
3.00	Total (sum of lines 1-2)	0	2,297,773		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-7 Part III Date/Time Prepared: 8/19/2013 4:34 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	16,839,707	0	16,839,707	0.596418	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,640,225	245,215	11,395,010	0.403582	0	2.00
3.00	Total (sum of lines 1-2)	28,479,932	245,215	28,234,717	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	0	658,393	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,639,380	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,297,773	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	130,394	39,152	-23,892	0	804,047	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-726,168	0	0	0	913,212	2.00
3.00	Total (sum of lines 1-2)	-595,774	39,152	-23,892	0	1,717,259	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-8 | Date/Time Prepared: 8/19/2013 4:34 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	-100,576	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,825	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,172,250			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	-128,727	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	-11,435	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	-470	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-803,708	CAP REL COSTS-MVBLE EQUIP	2.00	11	32.00
33.00	CREDENTIALING	B	-9,400	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.00
33.01	FITNESS CENTER	B	-24,675	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-8 | Date/Time Prepared: 8/19/2013 4:34 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	
33.02	MARKETING EXPENSE	A	-159,305	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.02
33.03	LOBBYING EXPENSE	A	-10,664	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.03
33.04	PROPERTY TAX	A	-23,892	CAP REL COSTS-BLDG & FIXT	1.00	13	33.04
33.05	ASSESSMENT TAX	A	-225,633	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.05
33.06	TELEPHONE SERVICES	A	-1,388	EMPLOYEE BENEFITS	4.00	0	33.06
33.07	TELEPHONE SERVICES	A	-3,681	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.07
33.08	TELEPHONE SERVICES	A	-3,540	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.08
33.09	PHARMACY	B	-44,767	PHARMACY	15.00	0	33.09
33.10	MISC REVENUE - DEF COMP	B	-127	EMPLOYEE BENEFITS	4.00	0	33.10
33.11			0		0.00	0	33.11
33.12			0		0.00	0	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,726,063				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-8-2 | Date/Time Prepared: 8/19/2013 4:34 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	65.00	RESPIRATORY THERAPY	117,827	117,827	0	0	0	1.00
2.00	91.00	EMERGENCY	1,237,668	757,158	480,509	0	0	2.00
3.00	91.00	EMERGENCY	54,620	54,620	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	242,645	242,645	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,652,760	1,172,250	480,509		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	65.00	RESPIRATORY THERAPY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	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	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	65.00	RESPIRATORY THERAPY	0	0	0	117,827		1.00
2.00	91.00	EMERGENCY	0	0	0	757,158		2.00
3.00	91.00	EMERGENCY	0	0	0	54,620		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	242,645		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,172,250		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/19/2013 4:34 pm

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					365	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					5.58	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	7,273.91	0.00	5,354.50	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.98	55.48	36.99	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)	36.99	36.99	27.74			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)					538,124	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)					538,124	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					198,063	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)					736,187	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)					736,187	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)					13,501	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)					13,501	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)					2,037	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					15,538	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)					15,538	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: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/19/2013 4:34 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)	73.98	55.48	36.99	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)	736,187		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	15,538		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)	751,725		63.00
64.00	Total cost of outside supplier services (from your records)	752,195		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	470		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	13,501		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,037		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	15,538		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	2,037		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	2,037		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: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/19/2013 4:34 pm

		Respiratory Therapy	Cost
		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	365	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	5.58	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	12,666.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	58.09	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)	29.05	29.05	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						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)	735,782	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)	735,782	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)	735,782	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)	735,782	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)	10,603	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)	10,603	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)	2,037	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	12,640	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)	12,640	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: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/19/2013 4:34 pm

		Respiratory 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)	58.09	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)		735,782	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		12,640	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)		748,422	63.00
64.00	Total cost of outside supplier services (from your records)		667,641	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		10,603	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		2,037	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		12,640	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		2,037	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		2,037	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: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/19/2013 4:34 pm

		Occupational Therapy	Cost
		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	365	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	5.58	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	388.76	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	70.11	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)	35.06	35.06	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)	27,256	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)	27,256	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)	27,256	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)	70.11	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	54,686	22.00
23.00	Total salary equivalency (see instructions)	54,686	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)	12,797	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)	12,797	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)	2,037	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	14,834	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)	14,834	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: 141312	Period: From 05/01/2012 To 04/30/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/19/2013 4:34 pm

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	70.11	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)		54,686	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		14,834	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)		69,520	63.00
64.00	Total cost of outside supplier services (from your records)		27,086	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		12,797	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		2,037	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		14,834	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		2,037	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		2,037	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: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part I | Date/Time Prepared: 8/19/2013 4:34 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	ADMISSIONS	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	804,047	804,047				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	913,212		913,212			2.00
4.00	00400	EMPLOYEE BENEFITS	3,561,089	3,591	383	3,565,063		4.00
5.01	00540	ADMISSIONS	367,267	6,348	3,130	141,537	518,282	5.01
5.02	00560	BUSINESS SERVICES	698,688	8,528	2,776	133,290	0	5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL	2,432,885	199,787	180,100	351,351	0	5.03
7.00	00700	OPERATION OF PLANT	1,254,187	94,487	30,098	132,048	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	88,925	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	281,278	6,305	0	96,653	0	9.00
10.00	01000	DIETARY	157,599	24,055	7,415	35,098	0	10.00
11.00	01100	CAFETERIA	182,933	15,303	0	69,407	0	11.00
13.00	01300	NURSING ADMINISTRATION	322,094	11,231	1,764	113,887	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	97,415	10,537	1,824	32,996	0	14.00
15.00	01500	PHARMACY	1,301,688	7,780	14,466	97,291	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	481,975	15,132	7,134	130,269	0	16.00
17.00	01700	SOCIAL SERVICE	195,999	1,635	0	74,836	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,790,992	88,652	66,823	655,845	23,469	30.00
31.00	03100	INTENSIVE CARE UNIT	34,632	17,792	10,006	8,337	920	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,074,819	80,360	210,127	281,780	50,341	50.00
53.00	05300	ANESTHESIOLOGY	3,875	0	768	0	7,401	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,856,947	53,954	238,611	237,715	137,400	54.00
60.00	06000	LABORATORY	1,633,087	22,131	50,624	285,882	103,715	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	66,055	0	0	0	1,082	62.00
64.00	06400	INTRAVENOUS THERAPY	195,634	11,423	6,316	72,193	4,383	64.00
65.00	06500	RESPIRATORY THERAPY	822,138	19,417	3,713	23,084	15,653	65.00
66.00	06600	PHYSICAL THERAPY	798,324	24,193	3,989	3,854	30,035	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,934	0	0	0	7,675	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	428,729	0	0	0	10,380	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	76,593	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	22,640	2,810	0	8,175	212	90.01
91.00	09100	EMERGENCY	1,948,309	51,037	49,819	430,144	49,023	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,826,396	776,488	889,886	3,415,672	518,282	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,948	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	387,749	0	7,839	70,012	0	194.00
194.01	07951	FOUNDATION	0	256	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	352,528	22,355	15,487	54,659	0	194.02
194.03	07953	ASHTON CLINIC	175,122	0	0	24,720	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	24,741,795	804,047	913,212	3,565,063	518,282	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part I | Date/Time Prepared: 8/19/2013 4:34 pm

		Cost Center Description	BUSINESS SERVICES	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
		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	00540	ADMISSIONS						5.01
5.02	00560	BUSINESS SERVICES	843,282					5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL	0	3,164,123	3,164,123			5.03
7.00	00700	OPERATION OF PLANT	0	1,510,820	221,545	1,732,365		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	88,925	13,040	0	101,965	8.00
9.00	00900	HOUSEKEEPING	0	384,236	56,344	22,231	0	9.00
10.00	01000	DIETARY	0	224,167	32,872	84,817	0	10.00
11.00	01100	CAFETERIA	0	267,643	39,247	53,957	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	448,976	65,837	39,601	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	142,772	20,936	37,152	0	14.00
15.00	01500	PHARMACY	0	1,421,225	208,407	27,431	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	634,510	93,044	53,355	0	16.00
17.00	01700	SOCIAL SERVICE	0	272,470	39,955	5,765	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,918	2,663,699	390,602	312,591	28,964	30.00
31.00	03100	INTENSIVE CARE UNIT	1,487	73,174	10,730	62,737	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	81,335	1,778,762	260,836	283,352	14,184	50.00
53.00	05300	ANESTHESIOLOGY	11,958	24,002	3,520	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	222,010	2,746,637	402,757	190,245	21,619	54.00
60.00	06000	LABORATORY	167,572	2,263,011	331,846	78,035	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,749	68,886	10,101	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	7,081	297,030	43,556	40,280	0	64.00
65.00	06500	RESPIRATORY THERAPY	28,301	912,306	133,780	68,464	0	65.00
66.00	06600	PHYSICAL THERAPY	48,527	908,922	133,283	85,307	12,607	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,401	29,010	4,254	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,770	455,879	66,850	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	123,752	200,345	29,378	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	342	34,179	5,012	9,910	0	90.01
91.00	09100	EMERGENCY	82,079	2,610,411	382,788	179,959	24,591	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	843,282	23,626,120	3,000,520	1,635,189	101,965	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,948	726	17,446	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	465,600	68,275	0	0	194.00
194.01	07951	FOUNDATION	0	256	38	904	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	445,029	65,259	78,826	0	194.02
194.03	07953	ASHTON CLINIC	0	199,842	29,305	0	0	194.03
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)	843,282	24,741,795	3,164,123	1,732,365	101,965	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part I | Date/Time Prepared: 8/19/2013 4:34 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		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	00540	ADMISSIONS						5.01
5.02	00560	BUSINESS SERVICES						5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	462,811					9.00
10.00	01000	DIETARY	22,954	364,810				10.00
11.00	01100	CAFETERIA	14,602	0	375,449			11.00
13.00	01300	NURSING ADMINISTRATION	10,717	0	13,149	578,280		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,054	0	7,623	0	218,537	14.00
15.00	01500	PHARMACY	7,424	0	8,488	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,439	0	27,262	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,560	0	8,488	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	84,597	283,763	104,690	252,049	0	30.00
31.00	03100	INTENSIVE CARE UNIT	16,978	5,641	965	3,354	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	76,683	0	36,783	100,740	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,486	0	36,649	0	0	54.00
60.00	06000	LABORATORY	21,118	0	52,794	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	10,901	75,406	8,854	23,819	0	64.00
65.00	06500	RESPIRATORY THERAPY	18,528	0	5,226	25,781	0	65.00
66.00	06600	PHYSICAL THERAPY	23,087	0	333	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	218,537	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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	2,682	0	1,165	1,574	0	90.01
91.00	09100	EMERGENCY	48,702	0	62,980	170,963	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	436,512	364,810	375,449	578,280	218,537	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,721	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	245	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	21,333	0	0	0	0	194.02
194.03	07953	ASHTON CLINIC	0	0	0	0	0	194.03
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)	462,811	364,810	375,449	578,280	218,537	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part I | Date/Time Prepared: 8/19/2013 4:34 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	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	00540	ADMISSIONS						5.01
5.02	00560	BUSINESS SERVICES						5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,672,975					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	822,610				16.00
17.00	01700	SOCIAL SERVICE	0	0	328,238			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	181,496	321,415	4,623,866	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	850	6,823	181,252	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	45,693	0	2,597,033	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	27,522	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	165,910	0	3,615,303	0	54.00
60.00	06000	LABORATORY	0	150,998	0	2,897,802	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	78,987	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	27,203	0	527,049	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	35,810	0	1,199,895	0	65.00
66.00	06600	PHYSICAL THERAPY	0	21,677	0	1,185,216	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	251,801	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	522,729	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,672,975	0	0	1,902,698	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	54,522	0	90.01
91.00	09100	EMERGENCY	0	192,973	0	3,673,367	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,672,975	822,610	328,238	23,339,042	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	27,841	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	533,875	0	194.00
194.01	07951	FOUNDATION	0	0	0	1,443	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	610,447	0	194.02
194.03	07953	ASHTON CLINIC	0	0	0	229,147	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,672,975	822,610	328,238	24,741,795	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part I | Date/Time Prepared: 8/19/2013 4:34 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	00540	ADMISSIONS	5.01
5.02	00560	BUSINESS SERVICES	5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL	5.03
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
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	4,623,866
31.00	03100	INTENSIVE CARE UNIT	181,252
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	2,597,033
53.00	05300	ANESTHESIOLOGY	27,522
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,615,303
60.00	06000	LABORATORY	2,897,802
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	78,987
64.00	06400	INTRAVENOUS THERAPY	527,049
65.00	06500	RESPIRATORY THERAPY	1,199,895
66.00	06600	PHYSICAL THERAPY	1,185,216
67.00	06700	OCCUPATIONAL THERAPY	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	251,801
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	522,729
73.00	07300	DRUGS CHARGED TO PATIENTS	1,902,698
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	0
90.01	09001	CLINIC	54,522
91.00	09100	EMERGENCY	3,673,367
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	
		SPECIAL PURPOSE COST CENTERS	
113.00	11300	INTEREST EXPENSE	
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,339,042
		NONREIMBURSABLE COST CENTERS	
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,841
194.00	07950	OCCUPATIONAL HEALTH	533,875
194.01	07951	FOUNDATION	1,443
194.02	07952	PHYSICIANS CLINICS	610,447
194.03	07953	ASHTON CLINIC	229,147
200.00		Cross Foot Adjustments	0
201.00		Negative Cost Centers	0
202.00		TOTAL (sum lines 118-201)	24,741,795

COST ALLOCATION STATISTICS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet Non-CMS W | Date/Time Prepared: 8/19/2013 4:34 pm

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS	4	GROSS SALARIES	4.00
5.01	ADMISSIONS	6	GROSS REVENUE	5.01
5.02	BUSINESS SERVICES	7	GROSS REVENUE	5.02
5.03	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.03
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	11	FTE'S	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	16	TIME SPENT	16.00
17.00	SOCIAL SERVICE	P	TOTAL PATIENT DAYS	17.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part II | Date/Time Prepared: 8/19/2013 4:34 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	3,591	383	3,974	3,974	4.00
5.01	00540	ADMISSIONS	0	6,348	3,130	9,478	158	5.01
5.02	00560	BUSINESS SERVICES	0	8,528	2,776	11,304	149	5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL	0	199,787	180,100	379,887	392	5.03
7.00	00700	OPERATION OF PLANT	0	94,487	30,098	124,585	147	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	6,305	0	6,305	108	9.00
10.00	01000	DIETARY	0	24,055	7,415	31,470	39	10.00
11.00	01100	CAFETERIA	0	15,303	0	15,303	77	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,231	1,764	12,995	127	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,537	1,824	12,361	37	14.00
15.00	01500	PHARMACY	0	7,780	14,466	22,246	109	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,132	7,134	22,266	145	16.00
17.00	01700	SOCIAL SERVICE	0	1,635	0	1,635	83	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	88,652	66,823	155,475	729	30.00
31.00	03100	INTENSIVE CARE UNIT	0	17,792	10,006	27,798	9	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	80,360	210,127	290,487	314	50.00
53.00	05300	ANESTHESIOLOGY	0	0	768	768	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	53,954	238,611	292,565	265	54.00
60.00	06000	LABORATORY	0	22,131	50,624	72,755	319	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	11,423	6,316	17,739	81	64.00
65.00	06500	RESPIRATORY THERAPY	0	19,417	3,713	23,130	26	65.00
66.00	06600	PHYSICAL THERAPY	0	24,193	3,989	28,182	4	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	2,810	0	2,810	9	90.01
91.00	09100	EMERGENCY	0	51,037	49,819	100,856	480	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	776,488	889,886	1,666,374	3,807	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,948	0	4,948	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	7,839	7,839	78	194.00
194.01	07951	FOUNDATION	0	256	0	256	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	22,355	15,487	37,842	61	194.02
194.03	07953	ASHTON CLINIC	0	0	0	0	28	194.03
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)	0	804,047	913,212	1,717,259	3,974	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part II | Date/Time Prepared: 8/19/2013 4:34 pm

		Cost Center Description	ADMISSIONS	BUSINESS SERVICES	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		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	00540	ADMISSIONS	9,636					5.01
5.02	00560	BUSINESS SERVICES	0	11,453				5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL	0	0	380,279			5.03
7.00	00700	OPERATION OF PLANT	0	0	26,627	151,359		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,567	0	1,567	8.00
9.00	00900	HOUSEKEEPING	0	0	6,772	1,942	0	9.00
10.00	01000	DIETARY	0	0	3,951	7,411	0	10.00
11.00	01100	CAFETERIA	0	0	4,717	4,714	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	7,913	3,460	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,516	3,246	0	14.00
15.00	01500	PHARMACY	0	0	25,048	2,397	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	11,183	4,662	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	4,802	504	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	437	514	46,945	27,312	445	30.00
31.00	03100	INTENSIVE CARE UNIT	17	20	1,290	5,481	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	937	1,103	31,349	24,757	218	50.00
53.00	05300	ANESTHESIOLOGY	138	162	423	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,548	3,029	48,400	16,622	332	54.00
60.00	06000	LABORATORY	1,930	2,272	39,883	6,818	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	20	24	1,214	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	82	96	5,235	3,519	0	64.00
65.00	06500	RESPIRATORY THERAPY	291	384	16,078	5,982	0	65.00
66.00	06600	PHYSICAL THERAPY	559	658	16,019	7,453	194	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	143	168	511	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	193	227	8,034	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,425	1,678	3,531	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	4	5	602	866	0	90.01
91.00	09100	EMERGENCY	912	1,113	46,006	15,723	378	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,636	11,453	360,616	142,869	1,567	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	87	1,524	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	8,206	0	0	194.00
194.01	07951	FOUNDATION	0	0	5	79	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	7,843	6,887	0	194.02
194.03	07953	ASHTON CLINIC	0	0	3,522	0	0	194.03
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)	9,636	11,453	380,279	151,359	1,567	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part II | Date/Time Prepared: 8/19/2013 4:34 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		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	00540	ADMISSIONS						5.01
5.02	00560	BUSINESS SERVICES						5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	15,127					9.00
10.00	01000	DIETARY	750	43,621				10.00
11.00	01100	CAFETERIA	477	0	25,288			11.00
13.00	01300	NURSING ADMINISTRATION	350	0	886	25,731		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	329	0	513	0	19,002	14.00
15.00	01500	PHARMACY	243	0	572	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	472	0	1,836	0	0	16.00
17.00	01700	SOCIAL SERVICE	51	0	572	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,765	33,931	7,053	11,216	0	30.00
31.00	03100	INTENSIVE CARE UNIT	555	674	65	149	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,506	0	2,477	4,482	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,683	0	2,468	0	0	54.00
60.00	06000	LABORATORY	690	0	3,556	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	356	9,016	596	1,060	0	64.00
65.00	06500	RESPIRATORY THERAPY	606	0	352	1,147	0	65.00
66.00	06600	PHYSICAL THERAPY	755	0	22	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	19,002	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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	88	0	78	70	0	90.01
91.00	09100	EMERGENCY	1,592	0	4,242	7,607	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,268	43,621	25,288	25,731	19,002	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	154	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	8	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	697	0	0	0	0	194.02
194.03	07953	ASHTON CLINIC	0	0	0	0	0	194.03
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)	15,127	43,621	25,288	25,731	19,002	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part II | Date/Time Prepared: 8/19/2013 4:34 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	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	00540	ADMISSIONS						5.01
5.02	00560	BUSINESS SERVICES						5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	50,615					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40,564				16.00
17.00	01700	SOCIAL SERVICE	0	0	7,647			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	8,950	7,488	303,260	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	42	159	36,259	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,253	0	360,883	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,491	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,181	0	376,093	0	54.00
60.00	06000	LABORATORY	0	7,446	0	135,669	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	1,258	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	1,341	0	39,121	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,766	0	49,762	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,069	0	54,915	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	19,824	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,454	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,615	0	0	57,249	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	4,532	0	90.01
91.00	09100	EMERGENCY	0	9,516	0	188,425	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	50,615	40,564	7,647	1,637,195	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	6,713	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	16,123	0	194.00
194.01	07951	FOUNDATION	0	0	0	348	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	53,330	0	194.02
194.03	07953	ASHTON CLINIC	0	0	0	3,550	0	194.03
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)	50,615	40,564	7,647	1,717,259	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part II | Date/Time Prepared: 8/19/2013 4:34 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	00540	ADMISSIONS			5.01
5.02	00560	BUSINESS SERVICES			5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL			5.03
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
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	303,260		30.00
31.00	03100	INTENSIVE CARE UNIT	36,259		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	360,883		50.00
53.00	05300	ANESTHESIOLOGY	1,491		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	376,093		54.00
60.00	06000	LABORATORY	135,669		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,258		62.00
64.00	06400	INTRAVENOUS THERAPY	39,121		64.00
65.00	06500	RESPIRATORY THERAPY	49,762		65.00
66.00	06600	PHYSICAL THERAPY	54,915		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,824		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,454		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,249		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
90.01	09001	CLINIC	4,532		90.01
91.00	09100	EMERGENCY	188,425		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,637,195		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,713		190.00
194.00	07950	OCCUPATIONAL HEALTH	16,123		194.00
194.01	07951	FOUNDATION	348		194.01
194.02	07952	PHYSICIANS CLINICS	53,330		194.02
194.03	07953	ASHTON CLINIC	3,550		194.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	1,717,259		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B-1 | Date/Time Prepared: 8/19/2013 4:34 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	ADMISSIONS (GROSS REVENUE)	BUSINESS SERVICES (GROSS REVENUE)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	75,242					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		836,021				2.00
4.00	00400	EMPLOYEE BENEFITS	336	351	8,837,733			4.00
5.01	00540	ADMISSIONS	594	2,865	350,867	47,513,609		5.01
5.02	00560	BUSINESS SERVICES	798	2,541	330,425	0	47,847,460	5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL	18,696	164,877	870,993	0	0	5.03
7.00	00700	OPERATION OF PLANT	8,842	27,554	327,346	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	590	0	239,601	0	0	9.00
10.00	01000	DIETARY	2,251	6,788	87,007	0	0	10.00
11.00	01100	CAFETERIA	1,432	0	172,060	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,051	1,615	282,325	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	986	1,670	81,796	0	0	14.00
15.00	01500	PHARMACY	728	13,243	241,182	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,416	6,531	322,936	0	0	16.00
17.00	01700	SOCIAL SERVICE	153	0	185,518	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,296	61,175	1,625,825	2,151,497	2,151,497	30.00
31.00	03100	INTENSIVE CARE UNIT	1,665	9,160	20,667	84,352	84,352	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,520	192,366	698,527	4,615,030	4,615,030	50.00
53.00	05300	ANESTHESIOLOGY	0	703	0	678,513	678,513	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,049	218,442	589,292	12,596,017	12,596,017	54.00
60.00	06000	LABORATORY	2,071	46,345	708,698	9,508,159	9,508,159	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	99,234	99,234	62.00
64.00	06400	INTRAVENOUS THERAPY	1,069	5,782	178,965	401,781	401,781	64.00
65.00	06500	RESPIRATORY THERAPY	1,817	3,399	57,225	1,434,993	1,605,798	65.00
66.00	06600	PHYSICAL THERAPY	2,264	3,652	9,554	2,753,475	2,753,475	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	703,621	703,621	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	951,562	951,562	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,021,771	7,021,771	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	263	0	20,265	19,395	19,395	90.01
91.00	09100	EMERGENCY	4,776	45,608	1,066,321	4,494,209	4,657,255	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	72,663	814,667	8,467,395	47,513,609	47,847,460	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	463	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	7,176	173,558	0	0	194.00
194.01	07951	FOUNDATION	24	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	2,092	14,178	135,500	0	0	194.02
194.03	07953	ASHTON CLINIC	0	0	61,280	0	0	194.03
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)	804,047	913,212	3,565,063	518,282	843,282	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.686146	1.092331	0.403391	0.010908	0.017624	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,974	9,636	11,453	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000450	0.000203	0.000239	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B-1 | Date/Time Prepared: 8/19/2013 4:34 pm

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.03	5.03	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	00540	ADMISSIONS						5.01
5.02	00560	BUSINESS SERVICES						5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL	-3,164,123	21,577,672				5.03
7.00	00700	OPERATION OF PLANT	0	1,510,820	45,976			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	88,925	0	146,638		8.00
9.00	00900	HOUSEKEEPING	0	384,236	590	0	45,386	9.00
10.00	01000	DIETARY	0	224,167	2,251	0	2,251	10.00
11.00	01100	CAFETERIA	0	267,643	1,432	0	1,432	11.00
13.00	01300	NURSING ADMINISTRATION	0	448,976	1,051	0	1,051	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	142,772	986	0	986	14.00
15.00	01500	PHARMACY	0	1,421,225	728	0	728	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	634,510	1,416	0	1,416	16.00
17.00	01700	SOCIAL SERVICE	0	272,470	153	0	153	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,663,699	8,296	41,653	8,296	30.00
31.00	03100	INTENSIVE CARE UNIT	0	73,174	1,665	0	1,665	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,778,762	7,520	20,398	7,520	50.00
53.00	05300	ANESTHESIOLOGY	0	24,002	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,746,637	5,049	31,091	5,049	54.00
60.00	06000	LABORATORY	0	2,263,011	2,071	0	2,071	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	68,886	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	297,030	1,069	0	1,069	64.00
65.00	06500	RESPIRATORY THERAPY	0	912,306	1,817	0	1,817	65.00
66.00	06600	PHYSICAL THERAPY	0	908,922	2,264	18,131	2,264	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	29,010	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	455,879	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	200,345	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	34,179	263	0	263	90.01
91.00	09100	EMERGENCY	0	2,610,411	4,776	35,365	4,776	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,164,123	20,461,997	43,397	146,638	42,807	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,948	463	0	463	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	465,600	0	0	0	194.00
194.01	07951	FOUNDATION	0	256	24	0	24	194.01
194.02	07952	PHYSICIANS CLINICS	0	445,029	2,092	0	2,092	194.02
194.03	07953	ASHTON CLINIC	0	199,842	0	0	0	194.03
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)		3,164,123	1,732,365	101,965	462,811	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.146639	37.679768	0.695352	10.197219	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		380,279	151,359	1,567	15,127	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.017624	3.292131	0.010686	0.333297	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B-1 | Date/Time Prepared: 8/19/2013 4:34 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		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	00540	ADMISSIONS						5.01
5.02	00560	BUSINESS SERVICES						5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	9,313					10.00
11.00	01100	CAFETERIA	0	11,279				11.00
13.00	01300	NURSING ADMINISTRATION	0	395	117,602			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	229	0	100		14.00
15.00	01500	PHARMACY	0	255	0	0	1,034,120	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	819	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	255	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,244	3,145	51,258	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	144	29	682	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,105	20,487	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,101	0	0	0	54.00
60.00	06000	LABORATORY	0	1,586	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1,925	266	4,844	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	157	5,243	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	10	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	100	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	1,034,120	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	35	320	0	0	90.01
91.00	09100	EMERGENCY	0	1,892	34,768	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,313	11,279	117,602	100	1,034,120	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	0	0	194.02
194.03	07953	ASHTON CLINIC	0	0	0	0	0	194.03
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)	364,810	375,449	578,280	218,537	1,672,975	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	39.172125	33.287437	4.917263	2,185.370000	1.617776	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	43,621	25,288	25,731	19,002	50,615	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.683883	2.242043	0.218797	190.020000	0.048945	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B-1 | Date/Time Prepared: 8/19/2013 4:34 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			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	00540	ADMISSIONS				5.01
5.02	00560	BUSINESS SERVICES				5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL				5.03
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	116,120			16.00
17.00	01700	SOCIAL SERVICE	0	1,780		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	25,620	1,743		30.00
31.00	03100	INTENSIVE CARE UNIT	120	37		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	6,450	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,420	0		54.00
60.00	06000	LABORATORY	21,315	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	3,840	0		64.00
65.00	06500	RESPIRATORY THERAPY	5,055	0		65.00
66.00	06600	PHYSICAL THERAPY	3,060	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
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
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC	0	0		90.01
91.00	09100	EMERGENCY	27,240	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	116,120	1,780		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0		194.00
194.01	07951	FOUNDATION	0	0		194.01
194.02	07952	PHYSICIANS CLINICS	0	0		194.02
194.03	07953	ASHTON CLINIC	0	0		194.03
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)	822,610	328,238		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.084137	184.403371		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	40,564	7,647		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.349328	4.296067		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet C Part I Date/Time Prepared: 8/19/2013 4:34 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	4,623,866		4,623,866	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	181,252		181,252	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,597,033		2,597,033	0	0	50.00
53.00	05300	ANESTHESIOLOGY	27,522		27,522	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,615,303		3,615,303	0	0	54.00
60.00	06000	LABORATORY	2,897,802		2,897,802	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	78,987		78,987	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	527,049		527,049	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,199,895	0	1,199,895	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,185,216	0	1,185,216	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	251,801		251,801	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	522,729		522,729	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,902,698		1,902,698	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	CLINIC	54,522		54,522	0	0	90.01
91.00	09100	EMERGENCY	3,673,367		3,673,367	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	872,427		872,427		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	24,211,469	0	24,211,469	0	0	200.00
201.00		Less Observation Beds	872,427		872,427		0	201.00
202.00		Total (see instructions)	23,339,042	0	23,339,042	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet C Part I Date/Time Prepared: 8/19/2013 4:34 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	1,718,557		1,718,557			30.00
31.00	03100	INTENSIVE CARE UNIT	84,352		84,352			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,034,242	3,580,788	4,615,030	0.562734	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	129,219	549,294	678,513	0.040562	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	712,843	11,883,174	12,596,017	0.287020	0.000000	54.00
60.00	06000	LABORATORY	843,123	8,665,036	9,508,159	0.304770	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	65,154	34,080	99,234	0.795967	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	600	401,181	401,781	1.311782	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	406,492	1,028,501	1,434,993	0.836168	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	155,834	2,597,641	2,753,475	0.430444	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	476,935	226,686	703,621	0.357865	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	852,642	98,920	951,562	0.549338	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,442,037	5,579,734	7,021,771	0.270971	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	CLINIC	0	19,395	19,395	2.811137	0.000000	90.01
91.00	09100	EMERGENCY	104,530	4,389,679	4,494,209	0.817356	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	432,940	432,940	2.015122	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	8,026,560	39,487,049	47,513,609			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,026,560	39,487,049	47,513,609			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet C Part I Date/Time Prepared: 8/19/2013 4:34 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
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		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: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part II Date/Time Prepared: 8/19/2013 4:34 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	360,883	4,615,030	0.078197	461,220	36,066	50.00
53.00	05300	ANESTHESIOLOGY	1,491	678,513	0.002197	56,988	125	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	376,093	12,596,017	0.029858	327,735	9,786	54.00
60.00	06000	LABORATORY	135,669	9,508,159	0.014269	479,519	6,842	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,258	99,234	0.012677	45,996	583	62.00
64.00	06400	INTRAVENOUS THERAPY	39,121	401,781	0.097369	557	54	64.00
65.00	06500	RESPIRATORY THERAPY	49,762	1,434,993	0.034678	289,414	10,036	65.00
66.00	06600	PHYSICAL THERAPY	54,915	2,753,475	0.019944	82,179	1,639	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,824	703,621	0.028174	327,335	9,222	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,454	951,562	0.008884	492,386	4,374	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,249	7,021,771	0.008153	777,323	6,338	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	CLINIC	4,532	19,395	0.233668	0	0	90.01
91.00	09100	EMERGENCY	188,425	4,494,209	0.041926	8,336	349	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	432,940	0.000000	0	0	92.00
200.00		Total (lines 50-199)	1,297,676	45,710,700		3,348,988	85,414	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV | Date/Time Prepared: 8/19/2013 4:34 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
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: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV Date/Time Prepared: 8/19/2013 4:34 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	4,615,030	0.000000	0.000000	461,220	50.00
53.00	05300	ANESTHESIOLOGY	0	678,513	0.000000	0.000000	56,988	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,596,017	0.000000	0.000000	327,735	54.00
60.00	06000	LABORATORY	0	9,508,159	0.000000	0.000000	479,519	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	99,234	0.000000	0.000000	45,996	62.00
64.00	06400	INTRAVENOUS THERAPY	0	401,781	0.000000	0.000000	557	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,434,993	0.000000	0.000000	289,414	65.00
66.00	06600	PHYSICAL THERAPY	0	2,753,475	0.000000	0.000000	82,179	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	703,621	0.000000	0.000000	327,335	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	951,562	0.000000	0.000000	492,386	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,021,771	0.000000	0.000000	777,323	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	CLINIC	0	19,395	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	4,494,209	0.000000	0.000000	8,336	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	432,940	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	45,710,700			3,348,988	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV | Date/Time Prepared: 8/19/2013 4:34 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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
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: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV | Date/Time Prepared: 8/19/2013 4:34 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
			23.00	24.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
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
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	CLINIC	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part V Date/Time Prepared: 8/19/2013 4:34 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	0.562734	0	1,548,475	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.040562	0	202,919	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.287020	0	4,143,707	0	0	54.00
60.00	06000	LABORATORY	0.304770	0	3,649,041	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.795967	0	18,487	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1.311782	0	249,125	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.836168	0	471,176	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.430444	0	924,999	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.357865	0	107,394	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.549338	0	10,805	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270971	0	2,641,612	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC	2.811137	0	8,589	0	0	90.01
91.00	09100	EMERGENCY	0.817356	0	1,251,318	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.015122	0	193,681	0	0	92.00
200.00		Subtotal (see instructions)		0	15,421,328	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	15,421,328	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part V Date/Time Prepared: 8/19/2013 4:34 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	871,380	0		50.00
53.00	05300	ANESTHESIOLOGY	8,231	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,189,327	0		54.00
60.00	06000	LABORATORY	1,112,118	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	14,715	0		62.00
64.00	06400	INTRAVENOUS THERAPY	326,798	0		64.00
65.00	06500	RESPIRATORY THERAPY	393,982	0		65.00
66.00	06600	PHYSICAL THERAPY	398,160	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,433	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,936	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	715,800	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC	24,145	0		90.01
91.00	09100	EMERGENCY	1,022,772	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	390,291	0		92.00
200.00		Subtotal (see instructions)	6,512,088	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	6,512,088	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141312 | Component CCN: 14Z312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part V Date/Time Prepared: 8/19/2013 4:34 pm

Title XVIII | Swing Beds - SNF

		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	0.562734	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.040562	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.287020	0	0	0	0	54.00
60.00	06000	LABORATORY	0.304770	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.795967	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1.311782	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.836168	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.430444	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.357865	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.549338	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270971	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC	2.811137	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.817356	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.015122	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: 141312 | Component CCN: 14Z312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part V | Date/Time Prepared: 8/19/2013 4:34 pm

Title XVIII | Swing Beds - SNF

		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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
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
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC	0	0		90.01
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: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-1 | Date/Time Prepared: 8/19/2013 4:34 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)	2,279	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,173	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,743	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	106	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,066	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	95	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,623,866	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	215,063	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,408,803	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,718,557	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,718,557	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	2.565410	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)	985.98	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)	4,408,803	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)	2,028.90	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,162,807	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)	2,162,807	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-1 | Date/Time Prepared: 8/19/2013 4:34 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	181,252	37	4,898.70	17	83,278	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)	1,421,852	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,667,937	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)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	192,746	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	192,746	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)	430	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,028.90	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	872,427	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-1 | Date/Time Prepared: 8/19/2013 4:34 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: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-3 | Date/Time Prepared: 8/19/2013 4:34 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		990,811		30.00
31.00	03100	INTENSIVE CARE UNIT		37,780		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.562734	461,220	259,544	50.00
53.00	05300	ANESTHESIOLOGY	0.040562	56,988	2,312	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.287020	327,735	94,066	54.00
60.00	06000	LABORATORY	0.304770	479,519	146,143	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.795967	45,996	36,611	62.00
64.00	06400	INTRAVENOUS THERAPY	1.311782	557	731	64.00
65.00	06500	RESPIRATORY THERAPY	0.836168	289,414	241,999	65.00
66.00	06600	PHYSICAL THERAPY	0.430444	82,179	35,373	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.357865	327,335	117,142	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.549338	492,386	270,486	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270971	777,323	210,632	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC	2.811137	0	0	90.01
91.00	09100	EMERGENCY	0.817356	8,336	6,813	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.015122	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,348,988	1,421,852	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)		3,348,988		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-3

Component CCN: 14Z312 | Date/Time Prepared: 8/19/2013 4:34 pm

Title XVIII | Swing Beds - SNF

		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	0.562734	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.040562	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.287020	1,682	483	54.00
60.00	06000	LABORATORY	0.304770	7,003	2,134	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.795967	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1.311782	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.836168	9,267	7,749	65.00
66.00	06600	PHYSICAL THERAPY	0.430444	33,573	14,451	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.357865	8,120	2,906	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.549338	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.270971	28,883	7,826	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC	2.811137	0	0	90.01
91.00	09100	EMERGENCY	0.817356	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.015122	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		88,528	35,549	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)		88,528		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141312	Period: From 05/01/2012 To 04/30/2013	Worksheet E Part B Date/Time Prepared: 8/19/2013 4:34 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,512,088	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)	6,512,088	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)	6,577,209	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)	24,474	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,387,258	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)	4,165,477	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)	4,165,477	30.00
31.00	Primary payer payments	48	31.00
32.00	Subtotal (line 30 minus line 31)	4,165,429	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)	426,993	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	426,993	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	208,157	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	4,592,422	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)	4,592,422	40.00
41.00	Interim payments	4,682,087	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)	-89,665	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	59,976	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

		Overrides 1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 8/19/2013 4:34 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		3,367,004		4,682,087	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,367,004		4,682,087	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		80,389		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		89,665	6.02
7.00	Total Medicare program liability (see instructions)		3,447,393		4,592,422	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: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 8/19/2013 4:34 pm

Component CCN: 14Z312 | Title XVIII | Swing Beds - SNF

		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		242,785		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		242,785		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		12,208		0	6.02
7.00	Total Medicare program liability (see instructions)		230,577		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141312	Period: From 05/01/2012 To 04/30/2013	Worksheet E-1 Part II Date/Time Prepared: 8/19/2013 4:34 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	628	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	1,083	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	155	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	1,780	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	47,513,609	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	1,731,899	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	3,357,757	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	3,095,402	8.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	2,909,356	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)	186,046	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141312 | Component CCN: 14Z312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet E-2 | Date/Time Prepared: 8/19/2013 4:34 pm

Title XVIII | Swing Beds - SNF

		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)	194,673	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)	35,904	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	95	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)	230,577	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	230,577	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)	230,577	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	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)	230,577	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)	230,577	0	19.00
20.00	Interim payments	242,785	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)	-12,208	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	2,104	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141312	Period: From 05/01/2012 To 04/30/2013	Worksheet E-3 Part V Date/Time Prepared: 8/19/2013 4:34 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	3,667,937	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)	3,667,937	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,704,616	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)	3,704,616	19.00
20.00	Deductibles (exclude professional component)	321,929	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	3,382,687	22.00
23.00	Coinsurance	578	23.00
24.00	Subtotal (line 22 minus line 23)	3,382,109	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	65,284	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	65,284	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	20,462	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,447,393	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)	3,447,393	30.00
31.00	Interim payments	3,367,004	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)	80,389	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	33,795	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet G | Date/Time Prepared: 8/19/2013 4:34 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	3,324,832	0	0	0	1.00
2.00	Temporary investments	6,493,615	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,119,088	0	0	0	4.00
5.00	Other receivable	2,020,575	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,707,898	0	0	0	6.00
7.00	Inventory	201,415	0	0	0	7.00
8.00	Prepaid expenses	673,163	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)	16,124,790	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,976,289	0	0	0	12.00
13.00	Land improvements	1,154,439	0	0	0	13.00
14.00	Accumulated depreciation	-957,551	0	0	0	14.00
15.00	Buildings	11,674,838	0	0	0	15.00
16.00	Accumulated depreciation	-6,076,735	0	0	0	16.00
17.00	Leasehold improvements	175,401	0	0	0	17.00
18.00	Accumulated depreciation	-41,511	0	0	0	18.00
19.00	Fixed equipment	1,060,011	0	0	0	19.00
20.00	Accumulated depreciation	-454,615	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	8,014,565	0	0	0	23.00
24.00	Accumulated depreciation	-5,282,291	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	3,424,390	0	0	0	27.00
28.00	Accumulated depreciation	-809,349	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)	14,857,881	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	536,532	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	554,107	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,090,639	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	32,073,310	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,381,248	0	0	0	37.00
38.00	Salaries, wages, and fees payable	506,476	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	449,287	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	1,367,088	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,704,099	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	5,600,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	585,392	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	6,185,392	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	9,889,491	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	22,183,819				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)	22,183,819	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	32,073,310	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet G-1 | Date/Time Prepared: 8/19/2013 4:34 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		18,075,837		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,107,983				2.00
3.00	Total (sum of line 1 and line 2)		22,183,820		0		3.00
4.00		0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		22,183,820		0		11.00
12.00	ROUNDING	1		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)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		22,183,819		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			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	ROUNDING		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: 141312 | Period: From 05/01/2012 To 04/30/2013 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/19/2013 4:34 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,718,557		1,718,557	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				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)	1,718,557		1,718,557	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	84,352		84,352	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)	84,352		84,352	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,802,909		1,802,909	17.00
18.00	Ancillary services	6,119,120	34,645,035	40,764,155	18.00
19.00	Outpatient services	104,530	4,842,014	4,946,544	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				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	1,532	1,336,384	1,337,916	27.00
27.01	CLINICS	0	665,819	665,819	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,028,091	41,489,252	49,517,343	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,467,858		29.00
30.00	BAD DEBT	2,455,227			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)		2,455,227		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)		29,923,085		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141312	Period: From 05/01/2012 To 04/30/2013	Worksheet G-3 Date/Time Prepared: 8/19/2013 4:34 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	49,517,343	1.00
2.00	Less contractual allowances and discounts on patients' accounts	19,196,055	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,321,288	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	29,923,085	4.00
5.00	Net income from service to patients (line 3 minus line 4)	398,203	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	100,703	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANT REVENUE, OTHER REVENUE	3,609,077	24.00
25.00	Total other income (sum of lines 6-24)	3,709,780	25.00
26.00	Total (line 5 plus line 25)	4,107,983	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,107,983	29.00