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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 141347

Period:
From 08/01/2012
To 07/31/2013

Worksheet S
Parts I-III
Date/Time Prepared:
12/23/2013 10:01 am

PART I - COST REPORT STATUS

Provider use only

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

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CARLINVILLE AREA HOSPITAL (141347) for the cost reporting period beginning 08/01/2012 and ending 07/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	186,436	-14,887	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	300,203	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	486,639	-14,887	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 12/23/2013 10:01 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 20733 NORTH BROAD STREET	PO Box:			1.00
2.00	City: CARLINVILLE	State: IL	Zip Code: 62626-	County: MACOUPIN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	CARLINVILLE AREA HOSPITAL	141347	99914	1	07/01/2005	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	CARLINVILLE AREA HOSPITAL SWING BED	14Z347	99914		07/01/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HOSPITAL-BASED HHA	147249	99914		01/05/1984	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) 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)	08/01/2012	07/31/2013	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify 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 St 1.00	Date of Geogra 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: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 12/23/2013 10:01 am

		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 this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)			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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 12/23/2013 10:01 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings		
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 12/23/2013 10:01 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. 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	67.00

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141347	Period: From 08/01/2012 To 07/31/2013	Worksheet S-2 Part I Date/Time Prepared: 12/23/2013 10:01 am

		V	XIX	
		1.00	2.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	142,414	0	0	118.01

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

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

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

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

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	Y	Y	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		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)	792,497	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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	05/07/2012	08/05/2012	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 12/23/2013 10:01 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
				Y/N	Legal Oper.
				1.00	2.00
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N	7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N	8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.			N	9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.			N	10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N	11.00
					Y/N
					1.00
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y 12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N 13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N 14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N 15.00
			Part A		Part B
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	11/27/2013	Y 16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N 18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N 19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N 20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet S-2 Part II Date/Time Prepared: 12/23/2013 10:01 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
			Y/N	Date		
			1.00	2.00		
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
			1.00	2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MICHAEL	BROWN		41.00
42.00	Enter the employer/company name of the cost report preparer		CARLINVILLE AREA HOSPITAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		217-854-7027	MBROWN@CAHCARE.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 12/23/2013 10:01 am

		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)	11/27/2013			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		CFO		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HFS Supplemental Information | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet S-2 Part IX Date/Time Prepared: 12/23/2013 10:01 am

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet S-3 Part I Date/Time Prepared: 12/23/2013 10:01 am

	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)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	32,544.00	0	1.00
2.00	HMO and other (see instructions)						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)		25	9,125	32,544.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	32,544.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (RHC)						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 12/23/2013 10:01 am

	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)(see instructions for col. 2 for the portion of LDP room available beds)	1,081	55	1,356			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,418	0	1,418			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	80			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,499	55	2,854			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)	2,499	55	2,854	0.00	133.89	14.00
15.00	CAH visits	11,306	2,826	22,028			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (RHC)						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	133.89	27.00
28.00	Observation Bed Days		17	208			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: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 12/23/2013 10:01 am

	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)(see instructions for col. 2 for the portion of LDP room available beds)		0	349	19	448	1.00
2.00	HMO and other (see instructions)			0			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	349	19	448	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (RHC)						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: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet S-10 | Date/Time Prepared: 12/23/2013 10:01 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.521357	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,163,718	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	720,150	5.00
6.00	Medicaid charges	4,907,693	6.00
7.00	Medicaid cost (line 1 times line 6)	2,558,660	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)	674,792	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	33,006	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 12 and 16)	8, 674,792	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	367,579	0	367,579	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	191,640	0	191,640	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)	191,640	0	191,640	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,289,035	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	411,774	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)	877,261	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	457,366	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	649,006	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,323,798	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet A | Date/Time Prepared: 12/23/2013 10:01 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,275,204	1,275,204	1,567,965	2,843,169	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		835,012	835,012	13,869	848,881	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,513,789	1,513,789	-1,136,125	377,664	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,153,356	2,000,574	3,153,930	145,566	3,299,496	5.00
7.00	00700	OPERATION OF PLANT	204,614	341,679	546,293	34,844	581,137	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	57,137	57,137	0	57,137	8.00
9.00	00900	HOUSEKEEPING	178,902	25,594	204,496	39,769	244,265	9.00
10.00	01000	DIETARY	131,144	166,815	297,959	28,925	326,884	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	278,972	13,891	292,863	48,960	341,823	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	205,698	126,274	331,972	28,507	360,479	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	188,313	30,622	218,935	15,998	234,933	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	896,051	102,601	998,652	156,412	1,155,064	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	227,529	227,663	455,192	29,254	484,446	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	430,987	609,914	1,040,901	93,014	1,133,915	54.00
60.00	06000	LABORATORY	510,192	462,342	972,534	90,913	1,063,447	60.00
65.00	06500	RESPIRATORY THERAPY	154,743	64,138	218,881	31,200	250,081	65.00
66.00	06600	PHYSICAL THERAPY	461,935	44,527	506,462	73,154	579,616	66.00
67.00	06700	OCCUPATIONAL THERAPY	136,532	3,075	139,607	23,141	162,748	67.00
69.00	06900	ELECTROCARDIOLOGY	47,111	13,976	61,087	9,921	71,008	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	68,014	156,723	224,737	18,121	242,858	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	193,430	668,448	861,878	33,560	895,438	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	145,344	8,816	154,160	26,358	180,518	90.00
91.00	09100	EMERGENCY	659,345	1,469,248	2,128,593	111,438	2,240,031	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,529,325	1,529,325	-1,529,325	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,272,212	11,747,387	18,019,599	-44,561	17,975,038	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	275,788	28,956	304,744	31,959	336,703	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	2,545	2,545	194.00
194.01	07951	FUND DEVELOPMENT	12,102	5,252	17,354	10,057	27,411	194.01
200.00		TOTAL (SUM OF LINES 118-199)	6,560,102	11,781,595	18,341,697	0	18,341,697	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet A | Date/Time Prepared: 12/23/2013 10:01 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-28,835	2,814,334		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-264,468	584,413		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	377,664		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-130,336	3,169,160		5.00
7.00	00700	OPERATION OF PLANT	-41	581,096		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	57,137		8.00
9.00	00900	HOUSEKEEPING	0	244,265		9.00
10.00	01000	DIETARY	-54,360	272,524		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	341,823		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-186	360,293		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	234,933		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,155,064		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,397	483,049		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-6,987	1,126,928		54.00
60.00	06000	LABORATORY	-150	1,063,297		60.00
65.00	06500	RESPIRATORY THERAPY	0	250,081		65.00
66.00	06600	PHYSICAL THERAPY	-275	579,341		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	162,748		67.00
69.00	06900	ELECTROCARDIOLOGY	-12,681	58,327		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	242,858		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-70,575	824,863		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-21,061	159,457		90.00
91.00	09100	EMERGENCY	-1,046,601	1,193,430		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,637,953	16,337,085		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	336,703		192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	2,545		194.00
194.01	07951	FUND DEVELOPMENT	0	27,411		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-1,637,953	16,703,744		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet Non-CMS Wo | Date/Time Prepared: 12/23/2013 10:01 am

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAPITAL RELATED COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
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
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
	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
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
69.00	ELECTROCARDIOLOGY	06900		69.00
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
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	09500		95.00
101.00	HOME HEALTH AGENCY	10100		101.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	11300		113.00
116.00	HOSPICE	11600		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
194.00	NONREIMBURSABLE COSTS CENTERS	07950		194.00
194.01	FUND DEVELOPMENT	07951		194.01
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet A-6 | Date/Time Prepared: 12/23/2013 10:01 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	B - RECLASS NONREIMBURSEABLE COSTS				
1.00	NONREIMBURSABLE COSTS CENTERS	194.00	0	2,545	1.00
	TOTALS		0	2,545	
	C - INSURANCE EXPENSE				
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	64,220	1.00
	TOTALS		0	64,220	
	E - INTEREST EXPENSE RECLASS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,166	1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,520,159	2.00
	TOTALS		0	1,529,325	
	F - RECLASS SALARIES FOR B-1 EMPL BEN				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	56	1.00
	TOTALS		0	56	
	H - DIRECTLY ASSIGN FICA				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	78,472	1.00
2.00	OPERATION OF PLANT	7.00	0	15,147	2.00
3.00	HOUSEKEEPING	9.00	0	13,506	3.00
4.00	DIETARY	10.00	0	9,228	4.00
5.00	NURSING ADMINISTRATION	13.00	0	29,263	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	15,376	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	64,492	7.00
8.00	OPERATING ROOM	50.00	0	16,123	8.00
9.00	NONPHYSICIAN ANESTHETISTS	19.00	0	9,432	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	31,322	10.00
11.00	LABORATORY	60.00	0	38,387	11.00
12.00	RESPIRATORY THERAPY	65.00	0	11,503	12.00
13.00	PHYSICAL THERAPY	66.00	0	33,760	13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	10,010	14.00
15.00	ELECTROCARDIOLOGY	69.00	0	3,355	15.00
16.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,990	16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	13,863	17.00
18.00	CLINIC	90.00	0	13,227	18.00
19.00	EMERGENCY	91.00	0	45,781	19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	12,262	20.00
21.00	FUND DEVELOPMENT	194.01	0	3,491	21.00
	TOTALS		0	472,990	
	I - DIRECTLY ASSIGN HEALTH INSURANCE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	131,314	1.00
2.00	OPERATION OF PLANT	7.00	0	19,697	2.00
3.00	HOUSEKEEPING	9.00	0	26,263	3.00
4.00	DIETARY	10.00	0	19,697	4.00
5.00	NURSING ADMINISTRATION	13.00	0	19,697	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	13,131	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	91,920	7.00
8.00	OPERATING ROOM	50.00	0	13,131	8.00
9.00	NONPHYSICIAN ANESTHETISTS	19.00	0	6,566	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	52,526	10.00
11.00	LABORATORY	60.00	0	52,526	11.00
12.00	RESPIRATORY THERAPY	65.00	0	19,697	12.00
13.00	PHYSICAL THERAPY	66.00	0	39,394	13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	13,131	14.00
15.00	ELECTROCARDIOLOGY	69.00	0	6,566	15.00
16.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	13,131	16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	19,697	17.00
18.00	CLINIC	90.00	0	13,131	18.00
19.00	EMERGENCY	91.00	0	65,657	19.00
20.00	FUND DEVELOPMENT	194.01	0	6,566	20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	19,697	21.00
	TOTALS		0	663,135	
500.00	Grand Total: Increases		0	2,732,271	500.00

RECLASSIFICATIONS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet A-6 | Date/Time Prepared: 12/23/2013 10:01 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	B - RECLASS NONREIMBURSEABLE COSTS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,545	9		1.00
	TOTALS		0	2,545			
	C - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	64,220	0		1.00
	TOTALS		0	64,220			
	E - INTEREST EXPENSE RECLASS						
1.00	INTEREST EXPENSE	113.00	0	1,529,325	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	1,529,325			
	F - RECLASS SALARIES FOR B-1 EMPL BEN						
1.00	ADMINISTRATIVE & GENERAL	5.00	56	0	0		1.00
	TOTALS		56	0			
	H - DIRECTLY ASSIGN FICA						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	472,990	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
	TOTALS		0	472,990			
	I - DIRECTLY ASSIGN HEALTH INSURANCE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	663,135	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
	TOTALS		0	663,135			
500.00	Grand Total: Decreases		56	2,732,215			500.00

RECLASSIFICATIONS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 12/23/2013 10:01 am

	Increases			Decreases			
	Cost Center	Line #	Salary	Cost Center	Line #	Salary	
	2.00	3.00	4.00	6.00	7.00	8.00	
	B - RECLASS NONREIMBURSEABLE COSTS						
1.00	NONREIMBURSABLE COSTS CENTERS	194.00	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
	TOTALS		0	TOTALS		0	
	C - INSURANCE EXPENSE						
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	ADMINISTRATIVE & GENERAL	5.00	0	1.00
	TOTALS		0	TOTALS		0	
	E - INTEREST EXPENSE RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	INTEREST EXPENSE	113.00	0	1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0		0.00	0	2.00
	TOTALS		0	TOTALS		0	
	F - RECLASS SALARIES FOR B-1 EMPL BEN						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	ADMINISTRATIVE & GENERAL	5.00	56	1.00
	TOTALS		0	TOTALS		56	
	H - DIRECTLY ASSIGN FICA						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1.00
2.00	OPERATION OF PLANT	7.00	0		0.00	0	2.00
3.00	HOUSEKEEPING	9.00	0		0.00	0	3.00
4.00	DIETARY	10.00	0		0.00	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0		0.00	0	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0		0.00	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	0		0.00	0	7.00
8.00	OPERATING ROOM	50.00	0		0.00	0	8.00
9.00	NONPHYSICIAN ANESTHETISTS	19.00	0		0.00	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0		0.00	0	10.00
11.00	LABORATORY	60.00	0		0.00	0	11.00
12.00	RESPIRATORY THERAPY	65.00	0		0.00	0	12.00
13.00	PHYSICAL THERAPY	66.00	0		0.00	0	13.00
14.00	OCCUPATIONAL THERAPY	67.00	0		0.00	0	14.00
15.00	ELECTROCARDIOLOGY	69.00	0		0.00	0	15.00
16.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0		0.00	0	16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0		0.00	0	17.00
18.00	CLINIC	90.00	0		0.00	0	18.00
19.00	EMERGENCY	91.00	0		0.00	0	19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	0		0.00	0	20.00
21.00	FUND DEVELOPMENT	194.01	0		0.00	0	21.00
	TOTALS		0	TOTALS		0	
	I - DIRECTLY ASSIGN HEALTH INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1.00
2.00	OPERATION OF PLANT	7.00	0		0.00	0	2.00
3.00	HOUSEKEEPING	9.00	0		0.00	0	3.00
4.00	DIETARY	10.00	0		0.00	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0		0.00	0	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0		0.00	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	0		0.00	0	7.00
8.00	OPERATING ROOM	50.00	0		0.00	0	8.00
9.00	NONPHYSICIAN ANESTHETISTS	19.00	0		0.00	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0		0.00	0	10.00
11.00	LABORATORY	60.00	0		0.00	0	11.00
12.00	RESPIRATORY THERAPY	65.00	0		0.00	0	12.00
13.00	PHYSICAL THERAPY	66.00	0		0.00	0	13.00
14.00	OCCUPATIONAL THERAPY	67.00	0		0.00	0	14.00
15.00	ELECTROCARDIOLOGY	69.00	0		0.00	0	15.00
16.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0		0.00	0	16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0		0.00	0	17.00
18.00	CLINIC	90.00	0		0.00	0	18.00
19.00	EMERGENCY	91.00	0		0.00	0	19.00
20.00	FUND DEVELOPMENT	194.01	0		0.00	0	20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0		0.00	0	21.00
	TOTALS		0	TOTALS		0	
500.00	Grand Total: Increases		0	Grand Total: Decreases		56	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet A-7 Part I Date/Time Prepared: 12/23/2013 10:01 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: 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	601,322	0	0	0	40,000	1.00
2.00	Land Improvements	1,320,019	38,795	0	38,795	0	2.00
3.00	Buildings and Fixtures	20,000,904	0	0	0	116,286	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	4,862,911	201,813	0	201,813	4,122	6.00
7.00	HIT designated Assets	1,032,307	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	27,817,463	240,608	0	240,608	160,408	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	27,817,463	240,608	0	240,608	160,408	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	561,322	0	1.00
2.00	Land Improvements	1,358,814	0	2.00
3.00	Buildings and Fixtures	19,884,618	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	5,060,602	0	6.00
7.00	HIT designated Assets	1,032,307	0	7.00
8.00	Subtotal (sum of lines 1-7)	27,897,663	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	27,897,663	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet A-7 Part II | Date/Time Prepared: 12/23/2013 10:01 am

	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	NEW CAP REL COSTS-BLDG & FIXT	1,275,204	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	835,012	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,110,216	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	NEW CAP REL COSTS-BLDG & FIXT	0	1,275,204	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	835,012	2.00
3.00	Total (sum of lines 1-2)	0	2,110,216	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet A-7 Part III Date/Time Prepared: 12/23/2013 10:01 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	21,873,020	0	21,873,020	0.784045	50,351	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	6,024,643	0	6,024,643	0.215955	13,869	2.00
3.00	Total (sum of lines 1-2)	27,897,663	0	27,897,663	1.000000	64,220	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	50,351	2,763,983	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	13,869	570,544	0	2.00
3.00	Total (sum of lines 1-2)	0	0	64,220	3,334,527	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	50,351	0	0	2,814,334	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	13,869	0	0	584,413	2.00
3.00	Total (sum of lines 1-2)	0	64,220	0	0	3,398,747	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet A-8 | Date/Time Prepared: 12/23/2013 10:01 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-21,779	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW 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)	B	-899	ADMINISTRATIVE & GENERAL	5.00	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)	A	-2,171	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,046,601			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	-52,291	DIETARY	10.00	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	B	-70,575	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-186	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
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	-264,468	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	DIETARY DISCOUNTS	B	-2,069	DIETARY	10.00	0	33.00
33.01	RADIOLOGY DISCOUNTS	B	-6,987	RADIOLOGY-DIAGNOSTIC	54.00	0	33.01
33.02	PT PROF FEES	B	-275	PHYSICAL THERAPY	66.00	0	33.02
33.03			0		0.00	0	33.03

ADJUSTMENTS TO EXPENSES | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet A-8 | Date/Time Prepared: 12/23/2013 10:01 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.04	CONTRACT LAB	B	-150	LABORATORY	60.00	0	33.04
33.05	SUPPLIES	B	-1,397	OPERATING ROOM	50.00	0	33.05
33.06	AHA & IHA DUES	A	-5,744	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07			0		0.00	9	33.07
36.00	TELEVISION DEPRECIATION	A	-5,087	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	36.00
37.00			0		0.00	0	37.00
39.00	MED STAFF RELATIONS	A	-11,061	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00			0		0.00	0	40.00
41.00			0		0.00	0	41.00
42.00	ADVERTISING	A	-86,150	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	TELEPHONE DEPRECIATION	A	-1,969	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	44.00
44.01	TELEPHONE TRUNKLINE CHARGES	A	-4,441	ADMINISTRATIVE & GENERAL	5.00	0	44.01
44.02	SPRINGFIELD CLINIC RENT	B	-21,061	CLINIC	90.00	0	44.02
44.03	PATIENT TELEVISION OFFSET	A	-2,340	ADMINISTRATIVE & GENERAL	5.00	0	44.03
44.04			0		0.00	0	44.04
44.05			0		0.00	0	44.05
44.06			0		0.00	0	44.06
44.07	PROP TAXES-POGUE BLDG	A	-805	ADMINISTRATIVE & GENERAL	5.00	0	44.07
45.00	PHYSICIAN RECRUITMENT	A	-16,669	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	PLANT OPERATIONS DISCOUNTS	B	-41	OPERATION OF PLANT	7.00	0	45.01
45.02			0		0.00	0	45.02
45.03	RECORD REVIEW COSTS	A	-56	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04			0		0.00	0	45.04
45.05	EKG PROFESSIONAL FEES	A	-12,681	ELECTROCARDIOLOGY	69.00	0	45.05
45.06			0		0.00	0	45.06
45.07			0		0.00	0	45.07
45.08			0		0.00	0	45.08
45.09			0		0.00	0	45.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,637,953				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet A-8-2 | Date/Time Prepared: 12/23/2013 10:01 am

	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	91.00	EMERGENCY	1,406,351	1,046,601	359,750	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		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			1,406,351	1,046,601	359,750		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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		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	91.00	EMERGENCY	0	0	0	1,046,601		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,046,601		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 12/23/2013 10:01 am

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					46	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.55	7.00
8.00	Optional travel expense rate per mile					0.55	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	372.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	74.59	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)	37.30	37.30	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)					27,785	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)					27,785	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)					27,785	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)					74.59	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					58,180	22.00
23.00	Total salary equivalency (see instructions)					58,180	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					1,716	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					1,716	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)					25	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					1,741	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					3,936	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					57	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 12/23/2013 10:01 am

Physical Therapy — Cost

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	74.59	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)	58,180	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	3,936	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	62,116	63.00
64.00	Total cost of outside supplier services (from your records)	18,625	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	1,716	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	25	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	1,741	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	25	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	25	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet B Part I Date/Time Prepared: 12/23/2013 10:01 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,814,334	2,814,334				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	584,413		584,413			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	377,664	0	0	377,664		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,169,160	568,784	88,312	66,397	3,892,653	5.00
7.00	00700	OPERATION OF PLANT	581,096	393,144	29,063	11,780	1,015,083	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	57,137	0	0	0	57,137	8.00
9.00	00900	HOUSEKEEPING	244,265	18,392	19	10,299	272,975	9.00
10.00	01000	DIETARY	272,524	70,808	17,634	7,550	368,516	10.00
11.00	01100	CAFETERIA	0	71,351	0	0	71,351	11.00
13.00	01300	NURSING ADMINISTRATION	341,823	11,686	658	16,060	370,227	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	360,293	52,712	4,554	11,842	429,401	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	234,933	3,895	36	10,841	249,705	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,155,064	552,660	37,665	51,586	1,796,975	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	483,049	259,367	60,846	13,099	816,361	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,126,928	174,161	254,976	24,812	1,580,877	54.00
60.00	06000	LABORATORY	1,063,297	72,633	11,532	29,372	1,176,834	60.00
65.00	06500	RESPIRATORY THERAPY	250,081	96,153	20,541	8,909	375,684	65.00
66.00	06600	PHYSICAL THERAPY	579,341	140,680	8,746	26,594	755,361	66.00
67.00	06700	OCCUPATIONAL THERAPY	162,748	8,580	0	7,860	179,188	67.00
69.00	06900	ELECTROCARDIOLOGY	58,327	0	7,824	2,712	68,863	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	242,858	40,779	1,046	3,916	288,599	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	824,863	31,755	7,255	11,136	875,009	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	159,457	95,759	2,946	8,367	266,529	90.00
91.00	09100	EMERGENCY	1,193,430	108,875	30,375	37,958	1,370,638	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,337,085	2,772,174	584,028	361,090	16,277,966	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9,024	20	0	9,044	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	336,703	30,128	55	15,877	382,763	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	2,545	0	0	0	2,545	194.00
194.01	07951	FUND DEVELOPMENT	27,411	3,008	310	697	31,426	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	16,703,744	2,814,334	584,413	377,664	16,703,744	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet B Part I Date/Time Prepared: 12/23/2013 10:01 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,892,653					5.00
7.00	00700	OPERATION OF PLANT	308,433	1,323,516				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,361	0	74,498			8.00
9.00	00900	HOUSEKEEPING	82,943	13,141	0	369,059		9.00
10.00	01000	DIETARY	111,974	50,591	0	14,249	545,330	10.00
11.00	01100	CAFETERIA	21,680	50,979	0	14,358	289,454	11.00
13.00	01300	NURSING ADMINISTRATION	112,493	8,350	0	2,352	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	130,473	37,662	0	10,607	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	75,873	2,783	0	784	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	546,016	394,867	38,100	111,210	255,876	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	248,051	185,314	6,950	52,193	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	480,349	124,435	6,819	35,046	0	54.00
60.00	06000	LABORATORY	357,581	51,895	0	14,616	0	60.00
65.00	06500	RESPIRATORY THERAPY	114,152	68,700	0	19,349	0	65.00
66.00	06600	PHYSICAL THERAPY	229,516	100,514	3,151	28,309	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	54,446	6,130	0	1,727	0	67.00
69.00	06900	ELECTROCARDIOLOGY	20,924	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	87,691	29,136	0	8,206	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	265,871	22,689	0	6,390	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	80,985	68,418	0	19,270	0	90.00
91.00	09100	EMERGENCY	416,468	77,790	19,478	21,909	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,763,280	1,293,394	74,498	360,575	545,330	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,748	6,447	0	1,816	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	116,303	21,526	0	6,063	0	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	773	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	9,549	2,149	0	605	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,892,653	1,323,516	74,498	369,059	545,330	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet B Part I Date/Time Prepared: 12/23/2013 10:01 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			11.00	13.00	16.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	447,822					11.00
13.00	01300	NURSING ADMINISTRATION	15,518	508,940				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,840	0	629,983			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	4,790	11,124	8,721	353,780		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	111,691	259,422	40,662	0	3,554,819	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,848	34,486	26,947	0	1,385,150	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	353,780	353,780	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,639	0	179,705	0	2,451,870	54.00
60.00	06000	LABORATORY	51,967	0	130,643	0	1,783,536	60.00
65.00	06500	RESPIRATORY THERAPY	14,608	0	24,840	0	617,333	65.00
66.00	06600	PHYSICAL THERAPY	34,054	0	42,784	0	1,193,689	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,537	0	13,598	0	265,626	67.00
69.00	06900	ELECTROCARDIOLOGY	4,406	0	13,963	0	108,156	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,711	0	20,316	0	441,659	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,165	28,255	36,351	0	1,246,730	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	15,614	36,267	4,712	0	491,795	90.00
91.00	09100	EMERGENCY	60,013	139,386	82,044	0	2,187,726	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	424,401	508,940	625,286	353,780	16,081,869	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	20,055	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,463	0	4,697	0	553,815	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	3,318	194.00
194.01	07951	FUND DEVELOPMENT	958	0	0	0	44,687	194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	447,822	508,940	629,983	353,780	16,703,744	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet B Part I Date/Time Prepared: 12/23/2013 10:01 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,554,819		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,385,150		50.00
53.00	05300	ANESTHESIOLOGY	0	353,780		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,451,870		54.00
60.00	06000	LABORATORY	0	1,783,536		60.00
65.00	06500	RESPIRATORY THERAPY	0	617,333		65.00
66.00	06600	PHYSICAL THERAPY	0	1,193,689		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	265,626		67.00
69.00	06900	ELECTROCARDIOLOGY	0	108,156		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	441,659		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,246,730		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	491,795		90.00
91.00	09100	EMERGENCY	0	2,187,726		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	16,081,869		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	20,055		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	553,815		192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	3,318		194.00
194.01	07951	FUND DEVELOPMENT	0	44,687		194.01
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	16,703,744		202.00

COST ALLOCATION STATISTICS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet Non-CMS Wo | Date/Time Prepared: 12/23/2013 10:01 am

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-17	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	6	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	8	MEALS SERVED	10.00
11.00	CAFETERIA	9	FTE'S	11.00
13.00	NURSING ADMINISTRATION	11	HOURS OF SERVICE	13.00
16.00	MEDICAL RECORDS & LIBRARY	14	GROSS REVENUE	16.00
19.00	NONPHYSICIAN ANESTHETISTS	16	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet B Part II Date/Time Prepared: 12/23/2013 10:01 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	35,351	568,784	88,312	692,447	0	5.00
7.00	00700	OPERATION OF PLANT	667	393,144	29,063	422,874	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	18,392	19	18,411	0	9.00
10.00	01000	DIETARY	1,538	70,808	17,634	89,980	0	10.00
11.00	01100	CAFETERIA	0	71,351	0	71,351	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,686	658	12,344	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	52,712	4,554	57,266	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	3,895	36	3,931	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,100	552,660	37,665	615,425	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	158,068	259,367	60,846	478,281	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,089	174,161	254,976	448,226	0	54.00
60.00	06000	LABORATORY	68,399	72,633	11,532	152,564	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,219	96,153	20,541	124,913	0	65.00
66.00	06600	PHYSICAL THERAPY	0	140,680	8,746	149,426	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,580	0	8,580	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	7,824	7,824	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	40,779	1,046	41,825	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	84,408	31,755	7,255	123,418	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	95,759	2,946	98,705	0	90.00
91.00	09100	EMERGENCY	0	108,875	30,375	139,250	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	400,839	2,772,174	584,028	3,757,041	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9,024	20	9,044	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,269	30,128	55	35,452	0	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	3,008	310	3,318	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	406,108	2,814,334	584,413	3,804,855	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet B Part II Date/Time Prepared: 12/23/2013 10:01 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	692,447					5.00
7.00	00700	OPERATION OF PLANT	54,866	477,740				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,088	0	3,088			8.00
9.00	00900	HOUSEKEEPING	14,755	4,743	0	37,909		9.00
10.00	01000	DIETARY	19,919	18,262	0	1,464	129,625	10.00
11.00	01100	CAFETERIA	3,857	18,402	0	1,475	68,803	11.00
13.00	01300	NURSING ADMINISTRATION	20,011	3,014	0	242	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,210	13,594	0	1,090	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	13,497	1,005	0	81	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	97,122	142,533	1,579	11,423	60,822	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,125	66,891	288	5,361	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	85,448	44,916	283	3,600	0	54.00
60.00	06000	LABORATORY	63,609	18,732	0	1,501	0	60.00
65.00	06500	RESPIRATORY THERAPY	20,306	24,798	0	1,987	0	65.00
66.00	06600	PHYSICAL THERAPY	40,828	36,282	131	2,908	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,685	2,213	0	177	0	67.00
69.00	06900	ELECTROCARDIOLOGY	3,722	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,599	10,517	0	843	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	47,295	8,190	0	656	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	14,406	24,696	0	1,979	0	90.00
91.00	09100	EMERGENCY	74,084	28,079	807	2,250	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	669,432	466,867	3,088	37,037	129,625	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	489	2,327	0	187	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,689	7,770	0	623	0	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	138	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	1,699	776	0	62	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	692,447	477,740	3,088	37,909	129,625	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet B Part II Date/Time Prepared: 12/23/2013 10:01 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			11.00	13.00	16.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	163,888					11.00
13.00	01300	NURSING ADMINISTRATION	5,679	41,290				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,993	0	103,153			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,753	903	1,428	22,598		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,875	21,047	6,658		997,484	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,434	2,798	4,412		607,590	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,336	0	29,430		628,239	54.00
60.00	06000	LABORATORY	19,018	0	21,390		276,814	60.00
65.00	06500	RESPIRATORY THERAPY	5,346	0	4,067		181,417	65.00
66.00	06600	PHYSICAL THERAPY	12,462	0	7,005		249,042	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,856	0	2,226		26,737	67.00
69.00	06900	ELECTROCARDIOLOGY	1,613	0	2,286		15,445	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,822	0	3,326		74,932	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,452	2,292	5,952		192,255	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,714	2,942	771		149,213	90.00
91.00	09100	EMERGENCY	21,963	11,308	13,433		291,174	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0		0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0		0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	155,316	41,290	102,384	0	3,690,342	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		12,047	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,221	0	769		73,524	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0		138	194.00
194.01	07951	FUND DEVELOPMENT	351	0	0		6,206	194.01
200.00		Cross Foot Adjustments				22,598	22,598	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	163,888	41,290	103,153	22,598	3,804,855	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet B Part II | Date/Time Prepared: 12/23/2013 10:01 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	997,484		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	607,590		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	628,239		54.00
60.00	06000	LABORATORY	0	276,814		60.00
65.00	06500	RESPIRATORY THERAPY	0	181,417		65.00
66.00	06600	PHYSICAL THERAPY	0	249,042		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	26,737		67.00
69.00	06900	ELECTROCARDIOLOGY	0	15,445		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	74,932		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	192,255		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	149,213		90.00
91.00	09100	EMERGENCY	0	291,174		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,690,342		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	12,047		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	73,524		192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	138		194.00
194.01	07951	FUND DEVELOPMENT	0	6,206		194.01
200.00		Cross Foot Adjustments	0	22,598		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	3,804,855		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet B-1 | Date/Time Prepared: 12/23/2013 10:01 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	57,075					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		529,229				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	6,560,046			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,535	79,973	1,153,300	-3,892,653	12,811,091	5.00
7.00	00700	OPERATION OF PLANT	7,973	26,319	204,614	0	1,015,083	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	57,137	8.00
9.00	00900	HOUSEKEEPING	373	17	178,902	0	272,975	9.00
10.00	01000	DIETARY	1,436	15,969	131,144	0	368,516	10.00
11.00	01100	CAFETERIA	1,447	0	0	0	71,351	11.00
13.00	01300	NURSING ADMINISTRATION	237	596	278,972	0	370,227	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,069	4,124	205,698	0	429,401	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79	33	188,313	0	249,705	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,208	34,108	896,051	0	1,796,975	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,260	55,101	227,529	0	816,361	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,532	230,899	430,987	0	1,580,877	54.00
60.00	06000	LABORATORY	1,473	10,443	510,192	0	1,176,834	60.00
65.00	06500	RESPIRATORY THERAPY	1,950	18,601	154,743	0	375,684	65.00
66.00	06600	PHYSICAL THERAPY	2,853	7,920	461,935	0	755,361	66.00
67.00	06700	OCCUPATIONAL THERAPY	174	0	136,532	0	179,188	67.00
69.00	06900	ELECTROCARDIOLOGY	0	7,085	47,111	0	68,863	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	827	947	68,014	0	288,599	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	644	6,570	193,430	0	875,009	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,942	2,668	145,344	0	266,529	90.00
91.00	09100	EMERGENCY	2,208	27,507	659,345	0	1,370,638	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	56,220	528,880	6,272,156	-3,892,653	12,385,313	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	18	0	0	9,044	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	611	50	275,788	0	382,763	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	2,545	194.00
194.01	07951	FUND DEVELOPMENT	61	281	12,102	0	31,426	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,814,334	584,413	377,664		3,892,653	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	49.309400	1.104272	0.057570		0.303850	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		692,447	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.054051	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet B-1 | Date/Time Prepared: 12/23/2013 10:01 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	37,567					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	96,866				8.00
9.00	00900	HOUSEKEEPING	373	0	37,194			9.00
10.00	01000	DIETARY	1,436	0	1,436	26,148		10.00
11.00	01100	CAFETERIA	1,447	0	1,447	13,879	9,350	11.00
13.00	01300	NURSING ADMINISTRATION	237	0	237	0	324	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,069	0	1,069	0	456	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79	0	79	0	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,208	49,539	11,208	12,269	2,332	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,260	9,037	5,260	0	310	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,532	8,867	3,532	0	932	54.00
60.00	06000	LABORATORY	1,473	0	1,473	0	1,085	60.00
65.00	06500	RESPIRATORY THERAPY	1,950	0	1,950	0	305	65.00
66.00	06600	PHYSICAL THERAPY	2,853	4,097	2,853	0	711	66.00
67.00	06700	OCCUPATIONAL THERAPY	174	0	174	0	220	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	92	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	827	0	827	0	161	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	644	0	644	0	254	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,942	0	1,942	0	326	90.00
91.00	09100	EMERGENCY	2,208	25,326	2,208	0	1,253	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	36,712	96,866	36,339	26,148	8,861	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	0	183	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	611	0	611	0	469	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	61	0	61	0	20	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,323,516	74,498	369,059	545,330	447,822	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	35.230814	0.769083	9.922541	20.855515	47.895401	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	477,740	3,088	37,909	129,625	163,888	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	12.717012	0.031879	1.019224	4.957358	17.528128	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet B-1 | Date/Time Prepared: 12/23/2013 10:01 am

		Cost Center Description	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			13.00	16.00	19.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	95,160				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,077,892			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	2,080	430,200	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	48,506	2,005,906			30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,448	1,329,324	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,864,978	0		54.00
60.00	06000	LABORATORY	0	6,444,847	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,225,410	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,110,618	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	670,812	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	688,838	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,002,225	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,283	1,793,247	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	6,781	232,428	0		90.00
91.00	09100	EMERGENCY	26,062	4,047,347	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	95,160	30,846,180	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	231,712	0		192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0		194.00
194.01	07951	FUND DEVELOPMENT	0	0	0		194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	508,940	629,983	353,780		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.348256	0.020271	3,537.800000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	41,290	103,153	22,598		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.433901	0.003319	225.980000		205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet B-2 | Date/Time Prepared: 12/23/2013 10:01 am

		Description	Worksheet Part	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet C Part I Date/Time Prepared: 12/23/2013 10:01 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,554,819		3,554,819	0	3,554,819	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,385,150		1,385,150	0	1,385,150	50.00
53.00	05300	ANESTHESIOLOGY	353,780		353,780	0	353,780	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,451,870		2,451,870	0	2,451,870	54.00
60.00	06000	LABORATORY	1,783,536		1,783,536	0	1,783,536	60.00
65.00	06500	RESPIRATORY THERAPY	617,333	0	617,333	0	617,333	65.00
66.00	06600	PHYSICAL THERAPY	1,193,689	0	1,193,689	0	1,193,689	66.00
67.00	06700	OCCUPATIONAL THERAPY	265,626	0	265,626	0	265,626	67.00
69.00	06900	ELECTROCARDIOLOGY	108,156		108,156	0	108,156	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	441,659		441,659	0	441,659	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,246,730		1,246,730	0	1,246,730	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	491,795		491,795	0	491,795	90.00
91.00	09100	EMERGENCY	2,187,726		2,187,726	0	2,187,726	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	247,270		247,270		247,270	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	16,329,139	0	16,329,139	0	16,329,139	200.00
201.00		Less Observation Beds	247,270		247,270		247,270	201.00
202.00		Total (see instructions)	16,081,869	0	16,081,869	0	16,081,869	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet C Part I Date/Time Prepared: 12/23/2013 10:01 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,626,890		1,626,890			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,619	1,321,705	1,329,324	1.041996	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,641	428,559	430,200	0.822362	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	655,139	8,209,839	8,864,978	0.276579	0.000000	54.00
60.00	06000	LABORATORY	723,130	5,721,717	6,444,847	0.276738	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	191,638	1,033,772	1,225,410	0.503777	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	427,401	1,683,217	2,110,618	0.565564	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	417,474	253,338	670,812	0.395977	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	37,050	651,788	688,838	0.157012	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	429,617	572,608	1,002,225	0.440678	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	843,913	949,334	1,793,247	0.695236	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,355	230,073	232,428	2.115903	0.000000	90.00
91.00	09100	EMERGENCY	108,723	3,938,624	4,047,347	0.540533	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	11,153	367,863	379,016	0.652400	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	5,483,743	25,362,437	30,846,180			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,483,743	25,362,437	30,846,180			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet C Part I Date/Time Prepared: 12/23/2013 10:01 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS			30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet D Part II Date/Time Prepared: 12/23/2013 10:01 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	607,590	1,329,324	0.457067	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	430,200	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	628,239	8,864,978	0.070868	449,075	31,825	54.00
60.00	06000	LABORATORY	276,814	6,444,847	0.042951	437,486	18,790	60.00
65.00	06500	RESPIRATORY THERAPY	181,417	1,225,410	0.148046	93,432	13,832	65.00
66.00	06600	PHYSICAL THERAPY	249,042	2,110,618	0.117995	70,640	8,335	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,737	670,812	0.039858	30,605	1,220	67.00
69.00	06900	ELECTROCARDIOLOGY	15,445	688,838	0.022422	20,851	468	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	74,932	1,002,225	0.074766	194,942	14,575	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	192,255	1,793,247	0.107211	368,477	39,505	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	149,213	232,428	0.641975	0	0	90.00
91.00	09100	EMERGENCY	291,174	4,047,347	0.071942	13,283	956	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	379,016	0.000000	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,692,858	29,219,290		1,678,791	129,506	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet D Part IV Date/Time Prepared: 12/23/2013 10:01 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	353,780	0	0	0	353,780	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
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	353,780	0	0	0	353,780	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet D Part IV | Date/Time Prepared: 12/23/2013 10:01 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,329,324	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	430,200	0.822362	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,864,978	0.000000	0.000000	449,075	54.00
60.00	06000	LABORATORY	0	6,444,847	0.000000	0.000000	437,486	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,225,410	0.000000	0.000000	93,432	65.00
66.00	06600	PHYSICAL THERAPY	0	2,110,618	0.000000	0.000000	70,640	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	670,812	0.000000	0.000000	30,605	67.00
69.00	06900	ELECTROCARDIOLOGY	0	688,838	0.000000	0.000000	20,851	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,002,225	0.000000	0.000000	194,942	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,793,247	0.000000	0.000000	368,477	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	232,428	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	4,047,347	0.000000	0.000000	13,283	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	379,016	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	29,219,290			1,678,791	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet D Part IV | Date/Time Prepared: 12/23/2013 10:01 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	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
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet D Part IV | Date/Time Prepared: 12/23/2013 10:01 am

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
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
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet D Part V Date/Time Prepared: 12/23/2013 10:01 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1.041996	0	688,202	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.822362	0	259,014	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.276579	0	3,666,763	0	0	54.00
60.00	06000	LABORATORY	0.276738	0	3,002,764	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.503777	0	315,820	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.565564	0	644,085	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.395977	0	54,733	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.157012	0	368,817	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.440678	0	321,793	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.695236	0	504,417	1,931	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2.115903	0	169,295	0	0	90.00
91.00	09100	EMERGENCY	0.540533	0	1,436,119	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.652400	0	188,600	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	11,620,422	1,931	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	11,620,422	1,931	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet D Part V Date/Time Prepared: 12/23/2013 10:01 am

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	717,104	0		50.00
53.00	05300	ANESTHESIOLOGY	213,003	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,014,150	0		54.00
60.00	06000	LABORATORY	830,979	0		60.00
65.00	06500	RESPIRATORY THERAPY	159,103	0		65.00
66.00	06600	PHYSICAL THERAPY	364,271	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	21,673	0		67.00
69.00	06900	ELECTROCARDIOLOGY	57,909	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	141,807	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	350,689	1,343		73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	358,212	0		90.00
91.00	09100	EMERGENCY	776,270	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	123,043	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,128,213	1,343		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,128,213	1,343		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141347 | Component CCN: 14Z347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet D Part V Date/Time Prepared: 12/23/2013 10:01 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.041996	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.822362	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.276579	0	0	0	0	54.00
60.00	06000	LABORATORY	0.276738	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.503777	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.565564	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.395977	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.157012	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.440678	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.695236	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.115903	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.540533	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.652400	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	0	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: 141347 | Component CCN: 14Z347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet D Part V | Date/Time Prepared: 12/23/2013 10:01 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
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
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
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
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: 141347	Period: From 08/01/2012 To 07/31/2013	Worksheet D-1 Date/Time Prepared: 12/23/2013 10:01 am
	Title XVIII	Hospital	Cost

	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS			
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,062	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,564	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.	do	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,356	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		482	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)		936	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		37	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)		43	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,081	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)		482	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)		936	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		121.04	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		124.67	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,554,819	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)		4,478	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)		5,361	25.00
26.00	Total swing-bed cost (see instructions)		1,695,543	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,859,276	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line minus line 36)	27	1,859,276	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,188.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,285,082	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,285,082	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet D-1 | Date/Time Prepared: 12/23/2013 10:01 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	696,952	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,982,034	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)	572,997	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,112,707	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,685,704	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)	208	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,188.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	247,270	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet D-1 | Date/Time Prepared: 12/23/2013 10:01 am

Title XVIII | Hospital | Cost

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet D-3 | Date/Time Prepared: 12/23/2013 10:01 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		827,472		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.041996	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.822362	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.276579	449,075	124,205	54.00
60.00	06000	LABORATORY	0.276738	437,486	121,069	60.00
65.00	06500	RESPIRATORY THERAPY	0.503777	93,432	47,069	65.00
66.00	06600	PHYSICAL THERAPY	0.565564	70,640	39,951	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.395977	30,605	12,119	67.00
69.00	06900	ELECTROCARDIOLOGY	0.157012	20,851	3,274	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.440678	194,942	85,907	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.695236	368,477	256,178	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.115903	0	0	90.00
91.00	09100	EMERGENCY	0.540533	13,283	7,180	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.652400	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,678,791	696,952	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,678,791		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141347 | Component CCN: 14Z347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet D-3 | Date/Time Prepared: 12/23/2013 10:01 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.041996	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.822362	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.276579	101,394	28,043	54.00
60.00	06000	LABORATORY	0.276738	162,614	45,001	60.00
65.00	06500	RESPIRATORY THERAPY	0.503777	84,313	42,475	65.00
66.00	06600	PHYSICAL THERAPY	0.565564	308,116	174,259	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.395977	340,532	134,843	67.00
69.00	06900	ELECTROCARDIOLOGY	0.157012	4,295	674	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.440678	197,836	87,182	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.695236	347,649	241,698	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.115903	0	0	90.00
91.00	09100	EMERGENCY	0.540533	7,590	4,103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.652400	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,554,339	758,278	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,554,339		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141347	Period: From 08/01/2012 To 07/31/2013	Worksheet E Part B Date/Time Prepared: 12/23/2013 10:01 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,129,556	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)	5,129,556	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)	5,180,852	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	37,172	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,716,656	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	3,427,024	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,427,024	30.00
31.00	Primary payer payments	1,091	31.00
32.00	Subtotal (line 30 minus line 31)	3,425,933	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)	364,512	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	364,512	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	342,340	36.00
37.00	Subtotal (see instructions)	3,790,445	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,790,445	40.00
40.01	Sequestration adjustment (see instructions)	25,396	40.01
41.00	Interim payments	3,779,936	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-14,887	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

		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: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 12/23/2013 10:01 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,453,527		3,387,516	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/19/2013	31,351	02/19/2013	126,816	3.01
3.02		05/16/2013	12,903	05/16/2013	12,148	3.02
3.03		07/31/2013	54,920	07/31/2013	253,456	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)		99,174		392,420	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,552,701		3,779,936	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		186,436		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		14,887	6.02
7.00	Total Medicare program liability (see instructions)		1,739,137		3,765,049	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141347 | Component CCN: 14Z347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 12/23/2013 10:01 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,062,350		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/19/2013	40,130		0	3.01
3.02		05/16/2013	26,176		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)		66,306		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,128,656		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		300,203		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,428,859		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141347	Period: From 08/01/2012 To 07/31/2013	Worksheet E-1 Part II Date/Time Prepared: 12/23/2013 10:01 am
	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	448	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	1,081	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	1,356	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	30,846,180	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	367,579	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	792,497	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	792,497	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	792,497	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	792,497	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141347 Component CCN: 14Z347	Period: From 08/01/2012 To 07/31/2013	Worksheet E-2 Date/Time Prepared: 12/23/2013 10:01 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,702,561	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)	765,861	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,418	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,468,422	0	8.00
9.00	Primary payer payments (see instructions)	4,200	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,464,222	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,464,222	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	18,980	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	2,445,242	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,445,242	0	19.00
19.01	Sequestration adjustment (see instructions)	16,383	0	19.01
20.00	Interim payments	2,128,656	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	300,203	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141347	Period: From 08/01/2012 To 07/31/2013	Worksheet E-3 Part V Date/Time Prepared: 12/23/2013 10:01 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	1,982,034	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	1,982,034	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,001,854	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)	2,001,854	19.00
20.00	Deductibles (exclude professional component)	295,936	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	1,705,918	22.00
23.00	Coinsurance	2,312	23.00
24.00	Subtotal (line 22 minus line 23)	1,703,606	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	47,262	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	47,262	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	40,451	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,750,868	28.00
29.00	-14011	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	1,750,868	30.00
30.01	Sequestration adjustment (see instructions)	11,731	30.01
31.00	Interim payments	1,552,701	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32	186,436	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet G | Date/Time Prepared: 12/23/2013 10:01 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,213,280	0	0	0	1.00
2.00	Temporary investments	101,876	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,822,569	0	0	0	4.00
5.00	Other receivable	358,008	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-928,000	0	0	0	6.00
7.00	Inventory	167,114	0	0	0	7.00
8.00	Prepaid expenses	210,385	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)	7,945,232	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	561,322	0	0	0	12.00
13.00	Land improvements	1,358,815	0	0	0	13.00
14.00	Accumulated depreciation	-260,476	0	0	0	14.00
15.00	Buildings	19,884,618	0	0	0	15.00
16.00	Accumulated depreciation	-3,535,746	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	4,992,335	0	0	0	23.00
24.00	Accumulated depreciation	-2,371,858	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	1,032,307	0	0	0	27.00
28.00	Accumulated depreciation	-528,029	0	0	0	28.00
29.00	Minor equipment-nondepreciable	68,266	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	21,201,554	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,847,062	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	936,197	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,783,259	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	33,930,045	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	560,360	0	0	0	37.00
38.00	Salaries, wages, and fees payable	610,622	0	0	0	38.00
39.00	Payroll taxes payable	22,252	0	0	0	39.00
40.00	Notes and loans payable (short term)	395,970	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	165,252	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,754,456	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	18,311,986	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	445,500	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	18,757,486	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	20,511,942	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	13,418,103				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	13,418,103	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	33,930,045	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet G-1 | Date/Time Prepared: 12/23/2013 10:01 am

		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		13,156,943		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		221,487				2.00
3.00	Total (sum of line 1 and line 2)		13,378,430		0		3.00
4.00	INCREASE IN PERM RESTRICTED	39,673		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)		39,673		0		10.00
11.00	Subtotal (line 3 plus line 10)		13,418,103		0		11.00
12.00		0		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)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,418,103		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	INCREASE IN PERM RESTRICTED		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			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: 141347 | Period: From 08/01/2012 To 07/31/2013 | Worksheet G-2 Parts I & II | Date/Time Prepared: 12/23/2013 10:01 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,248,706		1,248,706	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	608,549		608,549	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)	1,857,255		1,857,255	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,857,255		1,857,255	17.00
18.00	Ancillary services	3,923,629	27,293,032	31,216,661	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC (RHC)	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,780,884	27,293,032	33,073,916	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,341,697		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		18,341,697		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141347	Period: From 08/01/2012 To 07/31/2013	Worksheet G-3 Date/Time Prepared: 12/23/2013 10:01 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	33,073,916	1.00
2.00	Less contractual allowances and discounts on patients' accounts	15,214,810	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,859,106	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	18,341,697	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-482,591	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	22,527	6.00
7.00	Income from investments	47,725	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	14,085	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	52,291	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	25,014	22.00
23.00	Governmental appropriations	0	23.00
24.00	RENT	17,242	24.00
24.01	SALES TO NON PATIENTS	200,282	24.01
24.02	PHYSICAL THERAPY - NON PATIENTS	0	24.02
24.03	OTHER	78,550	24.03
24.04	GAIN FROM DISPOSAL OF PROPERTY AND E	35,507	24.04
24.05	TRANSFER FROM RELATED PARTY - FOUNDA	178,654	24.05
24.06	GRANTS	32,201	24.06
25.00	Total other income (sum of lines 6-24)	704,078	25.00
26.00	Total (line 5 plus line 25)	221,487	26.00
27.00		0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	221,487	29.00