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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141306	Period: From 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prepared: 11/15/2014 11:04 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/15/2014 Time: 11:04 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY MEMORIAL HOSPITAL (141306) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 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	-352,044	-32,053	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	121,436	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	-230,608	-32,053	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.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/15/2014 11:03 am

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

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	COMMUNITY MEMORIAL HOSPITAL	141306	99914	1	08/01/2000	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	COMMUNITY MEMORIAL HOSPITAL- SWB	14Z306	99914		08/01/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2013	06/30/2014	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
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)			22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3		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		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/15/2014 11:03 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
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)	N	N	39.00

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

		Y/N	IME	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, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/15/2014 11:03 am

		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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/15/2014 11:03 am

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	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 an approved GME 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 an approved GME 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/15/2014 11:03 am

		V	XIX	
		1.00	2.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	90,146	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 high cost 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141306	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/15/2014 11:03 am

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

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

		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)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		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)	07/01/2013	06/30/2014	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 11/15/2014 11:03 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	09/22/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 11/15/2014 11:03 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				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BRIAN	ENGELKE	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY MEMORIAL HOSPITAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(618) 635-4242	BENGELKE@STAUNTONHOSPITAL.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 11/15/2014 11:03 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)	09/22/2014			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		CFO		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/15/2014 11:03 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	10,406.00	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	10,406.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	10,406.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/15/2014 11:03 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)	368	21	457			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	547	0	588			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	23			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	915	21	1,068			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	915	21	1,068	0.00	107.54	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	107.54	27.00
28.00	Observation Bed Days		12	102			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	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/15/2014 11:03 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	124	11	223	1.00
2.00	HMO and other (see instructions)			0	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	124	11	223	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-10 | Date/Time Prepared: 11/15/2014 11:03 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)	0.500402	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,846,869	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	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	521,000	5.00
6.00	Medicaid charges	3,789,213	6.00
7.00	Medicaid cost (line 1 times line 6)	1,896,130	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	40,841	0	40,841	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	20,437	0	20,437	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)	20,437	0	20,437	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,439,584	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	224,204	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,215,380	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	608,179	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	628,616	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	628,616	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/15/2014 11:03 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	CAP REL COSTS-BLDG & FIXT		483,393	483,393	-453,960	29,433	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1		0	0	11,676	11,676	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2		0	0	88,917	88,917	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	394,680	394,680	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	4,288	4,288	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,410,281	1,410,281	195,272	1,605,553	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	853,280	1,149,306	2,002,586	-740,015	1,262,571	5.01
5.02	00550	DATA PROCESSING	0	0	0	268,387	268,387	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	0	0	230,183	230,183	5.03
7.00	00700	OPERATION OF PLANT	171,857	353,938	525,795	828	526,623	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,265	10,667	35,932	0	35,932	8.00
9.00	00900	HOUSEKEEPING	161,659	16,807	178,466	0	178,466	9.00
10.00	01000	DIETARY	112,633	87,887	200,520	-102,827	97,693	10.00
11.00	01100	CAFETERIA	0	0	0	102,827	102,827	11.00
13.00	01300	NURSING ADMINISTRATION	220,918	8,615	229,533	0	229,533	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	162,657	33,097	195,754	0	195,754	16.00
17.00	01700	SOCIAL SERVICE	58,978	0	58,978	0	58,978	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	208,072	208,072	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	871,367	53,644	925,011	0	925,011	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	200,815	53,209	254,024	0	254,024	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	212,093	212,093	-208,072	4,021	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	407,174	558,420	965,594	0	965,594	54.00
60.00	06000	LABORATORY	467,701	433,315	901,016	0	901,016	60.00
64.00	06400	INTRAVENOUS THERAPY	0	6,090	6,090	0	6,090	64.00
65.00	06500	RESPIRATORY THERAPY	166,740	174,161	340,901	-29,365	311,536	65.00
66.00	06600	PHYSICAL THERAPY	31,858	597,317	629,175	6,725	635,900	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	44,072	44,072	0	44,072	67.00
68.00	06800	SPEECH PATHOLOGY	0	13,701	13,701	0	13,701	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	95,680	153,937	249,617	29,365	278,982	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	164,294	638,732	803,026	0	803,026	73.00
76.00	03020	CARDIAC REHAB	62,831	1,854	64,685	0	64,685	76.00
76.01	03021	BEHAVIORAL HEALTH	123,803	112,835	236,638	0	236,638	76.01
76.02	03022	WOUND CARE	0	261,500	261,500	0	261,500	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	40,858	32,819	73,677	0	73,677	90.00
91.00	09100	EMERGENCY	432,272	1,412,180	1,844,452	0	1,844,452	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		3,041	3,041	-3,041	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,832,640	8,316,911	13,149,551	3,940	13,153,491	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	633,181	117,916	751,097	-3,940	747,157	192.00
194.00	07950	MOB	0	85,164	85,164	0	85,164	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	5,465,821	8,519,991	13,985,812	0	13,985,812	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/15/2014 11:03 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	29,433		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	11,676		1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	88,917		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-91,929	302,751		2.00
3.00	00300	OTHER CAP REL COSTS	-4,288	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-7,194	1,598,359		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	-524,032	738,539		5.01
5.02	00550	DATA PROCESSING	0	268,387		5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	230,183		5.03
7.00	00700	OPERATION OF PLANT	0	526,623		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	35,932		8.00
9.00	00900	HOUSEKEEPING	0	178,466		9.00
10.00	01000	DIETARY	-625	97,068		10.00
11.00	01100	CAFETERIA	-37,676	65,151		11.00
13.00	01300	NURSING ADMINISTRATION	-1,426	228,107		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,339	188,415		16.00
17.00	01700	SOCIAL SERVICE	0	58,978		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	208,072		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	925,011		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	254,024		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	4,021		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-242	965,352		54.00
60.00	06000	LABORATORY	-30,338	870,678		60.00
64.00	06400	INTRAVENOUS THERAPY	0	6,090		64.00
65.00	06500	RESPIRATORY THERAPY	-15,422	296,114		65.00
66.00	06600	PHYSICAL THERAPY	0	635,900		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	44,072		67.00
68.00	06800	SPEECH PATHOLOGY	0	13,701		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-2,133	276,849		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,178	801,848		73.00
76.00	03020	CARDIAC REHAB	-2,640	62,045		76.00
76.01	03021	BEHAVIORAL HEALTH	0	236,638		76.01
76.02	03022	WOUND CARE	0	261,500		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-10,300	63,377		90.00
91.00	09100	EMERGENCY	-454,329	1,390,123		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,191,091	11,962,400		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-21,782	725,375		192.00
194.00	07950	MOB	0	85,164		194.00
194.01	07951	MOB	0	0		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-1,212,873	12,772,939		200.00

RECLASSIFICATIONS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/15/2014 11:03 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT-BLDG 1	1.01	0	9,941		1.00
2.00	CAP REL COSTS-BLDG & FIXT-BLDG 2	1.02	0	79,575		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	358,809		3.00
4.00	OPERATION OF PLANT	7.00	0	828		4.00
5.00	PHYSICAL THERAPY	66.00	0	6,725		5.00
	TOTALS		0	455,878		
	B - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	47,382		1.00
	TOTALS		0	47,382		
	C - INTEREST EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,041		1.00
	TOTALS		0	3,041		
	D - EQUIPMENTAL RENTAL					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	20,791		1.00
	TOTALS		0	20,791		
	E - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	57,758	45,069		1.00
	TOTALS		57,758	45,069		
	F - OXYGEN EXPENSE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	29,365		1.00
	TOTALS		0	29,365		
	G - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	25,034		1.00
	TOTALS		0	25,034		
	H - ADVERTISING					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	3,940		1.00
	TOTALS		0	3,940		
	I - ADMINISTRATION					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	56,828	91,062		1.00
2.00	DATA PROCESSING	5.02	132,787	135,600		2.00
3.00	BILLING, COLLECTION, & ADMITTING	5.03	159,286	70,897		3.00
	TOTALS		348,901	297,559		
	J - CRNA					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	208,072		1.00
	TOTALS		0	208,072		
	K - PROPERTY TAX					
1.00	OTHER CAP REL COSTS	3.00	0	4,288		1.00
	TOTALS		0	4,288		
500.00	Grand Total: Increases		406,659	1,140,419		500.00

RECLASSIFICATIONS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/15/2014 11:03 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	455,878	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		0	455,878			
	B - EMPLOYEE BENEFITS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	47,382	0		1.00
	TOTALS		0	47,382			
	C - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	3,041	11		1.00
	TOTALS		0	3,041			
	D - EQUIPMENTAL RENTAL						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	20,791	10		1.00
	TOTALS		0	20,791			
	E - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	57,758	45,069	0		1.00
	TOTALS		57,758	45,069			
	F - OXYGEN EXPENSE						
1.00	RESPIRATORY THERAPY	65.00	0	29,365	0		1.00
	TOTALS		0	29,365			
	G - PROPERTY INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	25,034	0		1.00
	TOTALS		0	25,034			
	H - ADVERTISING						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,940	12		1.00
	TOTALS		0	3,940			
	I - ADMINISTRATION						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	348,901	297,559	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		348,901	297,559			
	J - CRNA						
1.00	ANESTHESIOLOGY	53.00	0	208,072	0		1.00
	TOTALS		0	208,072			
	K - PROPERTY TAX						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	4,288	0		1.00
	TOTALS		0	4,288			
500.00	Grand Total: Decreases		406,659	1,140,419			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 11/15/2014 11:03 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	520,386	0	0	0	0	1.00
2.00	Land Improvements	475,384	32,891	0	32,891	0	2.00
3.00	Buildings and Fixtures	3,432,958	40,000	0	40,000	0	3.00
4.00	Building Improvements	2,468,539	0	0	0	0	4.00
5.00	Fixed Equipment	164,020	14,184	0	14,184	0	5.00
6.00	Movable Equipment	4,701,176	1,548,159	0	1,548,159	60,815	6.00
7.00	HIT designated Assets	333,261	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	12,095,724	1,635,234	0	1,635,234	60,815	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	12,095,724	1,635,234	0	1,635,234	60,815	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	520,386	0	1.00
2.00	Land Improvements	508,275	0	2.00
3.00	Buildings and Fixtures	3,472,958	0	3.00
4.00	Building Improvements	2,468,539	0	4.00
5.00	Fixed Equipment	178,204	0	5.00
6.00	Movable Equipment	6,188,520	0	6.00
7.00	HIT designated Assets	333,261	0	7.00
8.00	Subtotal (sum of lines 1-7)	13,670,143	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	13,670,143	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part II Date/Time Prepared: 11/15/2014 11:03 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	CAP REL COSTS-BLDG & FIXT	483,393	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	483,393	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	483,393		1.00
1.01	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	0		1.01
1.02	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	0		1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	483,393		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part III Date/Time Prepared: 11/15/2014 11:03 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,028,661	0	1,028,661	0.076608	1,918	1.00
1.01	CAP REL COSTS-BLDG & FIXT- BLDG 1	930,645	0	930,645	0.069309	1,735	1.01
1.02	CAP REL COSTS-BLDG & FIXT- BLDG 2	5,010,853	0	5,010,853	0.373176	9,342	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	6,699,984	242,574	6,457,410	0.480907	12,039	2.00
3.00	Total (sum of lines 1-2)	13,670,143	242,574	13,427,569	1.000000	25,034	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1,918	27,515	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	0	1,735	9,941	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	0	9,342	79,575	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	12,039	269,921	20,791	2.00
3.00	Total (sum of lines 1-2)	0	0	25,034	386,952	20,791	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,918	0	0	29,433	1.00
1.01	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	1,735	0	0	11,676	1.01
1.02	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	9,342	0	0	88,917	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	12,039	0	0	302,751	2.00
3.00	Total (sum of lines 1-2)	0	25,034	0	0	432,777	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/15/2014 11:03 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 - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT- BLDG 1 (chapter 2)		0	CAP REL COSTS-BLDG & FIXT-BLDG 1	1.01	0	1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT- BLDG 2 (chapter 2)		0	CAP REL COSTS-BLDG & FIXT-BLDG 2	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-3,041	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-21,782	PHYSICIANS' PRIVATE OFFICES	192.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-73,410	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-10,660	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-10,300	CLINIC	90.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-7,183	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,784	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-500,089			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	-37,676	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-2,133	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-1,178	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,796	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT- BLDG 1		0	CAP REL COSTS-BLDG & FIXT-BLDG 1	1.01	0	26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT- BLDG 2		0	CAP REL COSTS-BLDG & FIXT-BLDG 2	1.02	0	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/15/2014 11:03 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	
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	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-88,888	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	IHA LOBBYING FEES	A	-7,144	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.00
33.01	TAXES	A	-4,288	OTHER CAP REL COSTS	3.00	13	33.01
33.02	MEDICAID PROVIDER TAX	A	-383,170	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.02
33.03	TRANSCRIPTION SERVICCE	B	-1,543	MEDICAL RECORDS & LIBRARY	16.00	0	33.03
33.04	MISCELLANEOUS OPERATING REVENUE	B	-4,460	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.04
33.05	X-RAY FILM COPYING	B	-242	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	INSERVICE EDUCATION	B	-1,426	NURSING ADMINISTRATION	13.00	0	33.06
33.07	CARDIAC REHAB	B	-2,640	CARDIAC REHAB	76.00	0	33.07
33.08	DIABETIC CONSULTATION	B	-625	DIETARY	10.00	0	33.08
33.09	PUBLIC RELATIONS SALARIES	A	-26,974	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.09
33.10	PUBLIC REATIONS OTHER	A	-5,059	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.10
33.11	PUBLIC RELATIONS BENEFITS	A	-7,194	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	PHYSICIAN ADVERTISING EXPENSE	A	-3,940	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.12
33.13	PHYSICIAN RECRUITMENT	A	-248	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,212,873				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 11/15/2014 11:03 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	60.00	LABORATORY	65,416	30,338	35,078	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	15,422	15,422	0	0	0	2.00
3.00	76.01	BEHAVIORAL HEALTH	30,125	0	30,125	0	0	3.00
4.00	91.00	EMERGENCY	1,360,266	454,329	905,937	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			1,471,229	500,089	971,140		0	200.00

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

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	30,338		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	15,422		2.00
3.00	76.01	BEHAVIORAL HEALTH	0	0	0	0		3.00
4.00	91.00	EMERGENCY	0	0	0	454,329		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	500,089		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/15/2014 11:03 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)					255	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	1,824.00	1,595.00	5,708.00	281.00	0.00	9.00
10.00	AHSEA (see instructions)	103.45	76.63	57.47	38.32	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)	38.32	38.32	28.74			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					188,693	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					122,225	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					328,039	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					638,957	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					10,768	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)					649,725	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					649,725	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					9,772	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					9,772	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,403	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					11,175	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)					11,175	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/15/2014 11:03 am

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.63	57.47	38.32	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)	649,725	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	11,175	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)	660,900	63.00
64.00	Total cost of outside supplier services (from your records)	581,280	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	9,772	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,403	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	11,175	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,403	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,403	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/15/2014 11:03 am

		Occupational Therapy	Cost
		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	127	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)	97	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	5.50	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	243.25	486.25	0.00	0.00	9.00
10.00	AHSEA (see instructions)	98.06	72.64	54.48	36.32	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.32	36.32	27.24			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)	17,670	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	26,491	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	44,161	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)	44,161	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)	60.54	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	47,221	22.00
23.00	Total salary equivalency (see instructions)	47,221	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	4,613	24.00
25.00	Assistants (line 4 times column 3, line 11)	2,642	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	7,255	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,232	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	8,487	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	8,487	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/15/2014 11:03 am

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.64	54.48	36.32	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)	47,221	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	8,487	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)	55,708	63.00
64.00	Total cost of outside supplier services (from your records)	44,072	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	7,255	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,232	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	8,487	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,232	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,232	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/15/2014 11:03 am

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					82	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	200.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	94.23	69.80	52.35	34.90	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.90	34.90	26.18			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)					13,960	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)					13,960	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)					13,960	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					69.80	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					54,444	22.00
23.00	Total salary equivalency (see instructions)					54,444	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)					2,862	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)					2,862	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)					451	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					3,313	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)					2,862	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/15/2014 11:03 am

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.80	52.35	34.90	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	54,444	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	2,862	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)	57,306	63.00
64.00	Total cost of outside supplier services (from your records)	13,701	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	2,862	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	451	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	3,313	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	451	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	451	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/15/2014 11:03 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT- BLDG 1	BLDG & FIXT- BLDG 2	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	29,433	29,433				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1	11,676	0	11,676			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2	88,917	0	0	88,917		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	302,751				302,751	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,598,359	0	0	0	0	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	738,539	3,560	3,149	3,367	36,302	5.01
5.02	00550	DATA PROCESSING	268,387	0	0	0	0	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	230,183	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	526,623	6,853	3,402	17,791	69,870	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	35,932	593	656	0	6,044	8.00
9.00	00900	HOUSEKEEPING	178,466	529	214	1,580	5,397	9.00
10.00	01000	DIETARY	97,068	753	0	3,547	7,681	10.00
11.00	01100	CAFETERIA	65,151	531	0	2,501	5,416	11.00
13.00	01300	NURSING ADMINISTRATION	228,107	294	0	1,384	2,996	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	188,415	551	74	2,280	5,615	16.00
17.00	01700	SOCIAL SERVICE	58,978	118	0	556	1,204	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	208,072	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	925,011	4,864	0	22,904	49,594	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	254,024	1,881	0	8,856	19,175	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	4,021	41	0	191	414	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	965,352	2,085	0	9,817	21,256	54.00
60.00	06000	LABORATORY	870,678	775	858	0	7,903	60.00
64.00	06400	INTRAVENOUS THERAPY	6,090	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	296,114	537	0	2,527	5,472	65.00
66.00	06600	PHYSICAL THERAPY	635,900	0	0	0	12,043	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,072	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,701	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	276,849	673	745	0	6,864	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	801,848	281	0	1,321	2,860	73.00
76.00	03020	CARDIAC REHAB	62,045	738	0	3,474	7,523	76.00
76.01	03021	BEHAVIORAL HEALTH	236,638	1,233	1,364	0	12,570	76.01
76.02	03022	WOUND CARE	261,500	275	305	0	2,808	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	63,377	500	0	2,357	5,103	90.00
91.00	09100	EMERGENCY	1,390,123	847	0	3,991	8,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,962,400	28,512	10,767	88,444	302,751	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	100	0	473	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	725,375	803	889	0	0	192.00
194.00	07950	MOB	85,164	18	20	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,772,939	29,433	11,676	88,917	302,751	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/15/2014 11:03 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	Subtotal	DATA PROCESSING	
			4.00	4A	5.01	5A.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,598,359					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	141,780	926,697	926,697			5.01
5.02	00550	DATA PROCESSING	39,435	307,822	24,080	331,902	331,902	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	47,305	277,488	21,707	299,195	7,982	5.03
7.00	00700	OPERATION OF PLANT	51,038	675,577	52,848	728,425	19,433	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,503	50,728	3,968	54,696	1,459	8.00
9.00	00900	HOUSEKEEPING	48,010	234,196	18,320	252,516	6,737	9.00
10.00	01000	DIETARY	16,297	125,346	9,805	135,151	3,606	10.00
11.00	01100	CAFETERIA	17,153	90,752	7,099	97,851	2,610	11.00
13.00	01300	NURSING ADMINISTRATION	65,608	298,389	23,342	321,731	8,583	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	48,306	245,241	19,184	264,425	7,054	16.00
17.00	01700	SOCIAL SERVICE	17,515	78,371	6,131	84,502	2,254	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	208,072	16,277	224,349	5,985	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	258,782	1,261,155	98,656	1,359,811	36,277	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	59,638	343,574	26,877	370,451	9,883	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	4,667	365	5,032	134	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	120,923	1,119,433	87,570	1,207,003	32,200	54.00
60.00	06000	LABORATORY	138,898	1,019,112	79,722	1,098,834	29,315	60.00
64.00	06400	INTRAVENOUS THERAPY	0	6,090	476	6,566	175	64.00
65.00	06500	RESPIRATORY THERAPY	49,519	354,169	27,706	381,875	10,188	65.00
66.00	06600	PHYSICAL THERAPY	9,461	657,404	51,427	708,831	18,910	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	44,072	3,448	47,520	1,268	67.00
68.00	06800	SPEECH PATHOLOGY	0	13,701	1,072	14,773	394	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,415	313,546	24,528	338,074	9,019	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,792	855,102	66,892	921,994	24,597	73.00
76.00	03020	CARDIAC REHAB	18,660	92,440	7,231	99,671	2,659	76.00
76.01	03021	BEHAVIORAL HEALTH	36,767	288,572	22,574	311,146	8,301	76.01
76.02	03022	WOUND CARE	0	264,888	20,721	285,609	7,619	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	12,134	83,471	6,530	90,001	2,401	90.00
91.00	09100	EMERGENCY	128,377	1,531,979	119,845	1,651,824	44,069	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,410,316	11,772,054	848,401	11,693,758	303,112	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	573	45	618	16	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	188,043	915,110	71,586	986,696	26,323	192.00
194.00	07950	MOB	0	85,202	6,665	91,867	2,451	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,598,359	12,772,939	926,697	12,772,939	331,902	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/15/2014 11:03 am

		Cost Center Description	BILLING, COLLECTION, & ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.03	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	307,177					5.03
7.00	00700	OPERATION OF PLANT	0	747,858				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,944	78,099			8.00
9.00	00900	HOUSEKEEPING	0	19,594	0	278,847		9.00
10.00	01000	DIETARY	0	27,888	0	11,505	178,150	10.00
11.00	01100	CAFETERIA	0	19,662	0	8,112	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,877	0	4,487	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,387	0	8,411	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,372	0	1,804	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,503	180,066	78,099	74,287	178,150	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,982	69,618	0	28,721	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	3,850	1,503	0	620	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	85,703	77,174	0	31,839	0	54.00
60.00	06000	LABORATORY	81,206	28,694	0	11,838	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,428	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	21,101	19,867	0	8,196	0	65.00
66.00	06600	PHYSICAL THERAPY	31,799	43,725	0	18,039	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,798	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	270	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,474	24,923	0	10,282	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,294	10,385	0	4,284	0	73.00
76.00	03020	CARDIAC REHAB	1,112	27,314	0	11,269	0	76.00
76.01	03021	BEHAVIORAL HEALTH	5,743	45,638	0	18,828	0	76.01
76.02	03022	WOUND CARE	7,485	10,193	0	4,205	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	383	18,528	0	7,644	0	90.00
91.00	09100	EMERGENCY	18,790	31,373	0	12,943	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	302,921	713,725	78,099	277,314	178,150	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,717	0	1,533	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,256	29,733	0	0	0	192.00
194.00	07950	MOB	0	683	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	307,177	747,858	78,099	278,847	178,150	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/15/2014 11:03 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	128,235					11.00
13.00	01300	NURSING ADMINISTRATION	8,076	353,754				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,946	0	306,223			16.00
17.00	01700	SOCIAL SERVICE	2,156	0	0	95,088		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	230,334	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,851	199,474	10,618	95,088	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,341	45,971	7,058	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	3,892	0	230,334	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,885	0	86,641	0	0	54.00
60.00	06000	LABORATORY	17,097	0	82,090	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	1,444	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,095	0	21,331	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,165	0	32,145	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,817	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	273	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,498	0	5,534	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,006	0	19,504	0	0	73.00
76.00	03020	CARDIAC REHAB	2,297	0	1,124	0	0	76.00
76.01	03021	BEHAVIORAL HEALTH	4,526	0	5,805	0	0	76.01
76.02	03022	WOUND CARE	0	0	7,566	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,494	9,353	387	0	0	90.00
91.00	09100	EMERGENCY	15,802	98,956	18,994	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	128,235	353,754	306,223	95,088	230,334	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	128,235	353,754	306,223	95,088	230,334	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/15/2014 11:03 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1					1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,254,224	0	2,254,224		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	546,025	0	546,025		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	245,365	0	245,365		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,535,445	0	1,535,445		54.00
60.00	06000	LABORATORY	1,349,074	0	1,349,074		60.00
64.00	06400	INTRAVENOUS THERAPY	9,613	0	9,613		64.00
65.00	06500	RESPIRATORY THERAPY	468,653	0	468,653		65.00
66.00	06600	PHYSICAL THERAPY	854,614	0	854,614		66.00
67.00	06700	OCCUPATIONAL THERAPY	52,403	0	52,403		67.00
68.00	06800	SPEECH PATHOLOGY	15,710	0	15,710		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	396,804	0	396,804		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,006,064	0	1,006,064		73.00
76.00	03020	CARDIAC REHAB	145,446	0	145,446		76.00
76.01	03021	BEHAVIORAL HEALTH	399,987	0	399,987		76.01
76.02	03022	WOUND CARE	322,677	0	322,677		76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	130,191	0	130,191		90.00
91.00	09100	EMERGENCY	1,892,751	0	1,892,751		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,625,046	0	11,625,046		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,884	0	5,884		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,047,008	0	1,047,008		192.00
194.00	07950	MOB	95,001	0	95,001		194.00
194.01	07951	MOB	0	0	0		194.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	12,772,939	0	12,772,939		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/15/2014 11:03 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	BLDG & FIXT-BLDG 1	BLDG & FIXT-BLDG 2	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	0	3,560	3,149	3,367	36,302	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	0	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	828	6,853	3,402	17,791	69,870	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	593	656	0	6,044	8.00
9.00	00900	HOUSEKEEPING	0	529	214	1,580	5,397	9.00
10.00	01000	DIETARY	0	753	0	3,547	7,681	10.00
11.00	01100	CAFETERIA	0	531	0	2,501	5,416	11.00
13.00	01300	NURSING ADMINISTRATION	0	294	0	1,384	2,996	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	551	74	2,280	5,615	16.00
17.00	01700	SOCIAL SERVICE	0	118	0	556	1,204	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,864	0	22,904	49,594	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,881	0	8,856	19,175	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	41	0	191	414	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,085	0	9,817	21,256	54.00
60.00	06000	LABORATORY	0	775	858	0	7,903	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	537	0	2,527	5,472	65.00
66.00	06600	PHYSICAL THERAPY	6,725	0	0	0	12,043	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	673	745	0	6,864	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	281	0	1,321	2,860	73.00
76.00	03020	CARDIAC REHAB	0	738	0	3,474	7,523	76.00
76.01	03021	BEHAVIORAL HEALTH	0	1,233	1,364	0	12,570	76.01
76.02	03022	WOUND CARE	0	275	305	0	2,808	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	500	0	2,357	5,103	90.00
91.00	09100	EMERGENCY	0	847	0	3,991	8,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,553	28,512	10,767	88,444	302,751	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	100	0	473	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	803	889	0	0	192.00
194.00	07950	MOB	41,015	18	20	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	48,568	29,433	11,676	88,917	302,751	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/15/2014 11:03 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	OTHER ADMINISTRATIVE AND GENERAL	DATA PROCESSING	BILLING, COLLECTION, & ADMITTING	
			2A	4.00	5.01	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	46,378	0	46,378			5.01
5.02	00550	DATA PROCESSING	0	0	1,205	1,205		5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	0	1,086	29	1,115	5.03
7.00	00700	OPERATION OF PLANT	98,744	0	2,645	71	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,293	0	199	5	0	8.00
9.00	00900	HOUSEKEEPING	7,720	0	917	24	0	9.00
10.00	01000	DIETARY	11,981	0	491	13	0	10.00
11.00	01100	CAFETERIA	8,448	0	355	9	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,674	0	1,168	31	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,520	0	960	26	0	16.00
17.00	01700	SOCIAL SERVICE	1,878	0	307	8	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	815	22	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	77,362	0	4,937	132	38	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,912	0	1,345	36	25	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	646	0	18	0	14	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,158	0	4,383	117	316	54.00
60.00	06000	LABORATORY	9,536	0	3,990	107	293	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	24	1	5	64.00
65.00	06500	RESPIRATORY THERAPY	8,536	0	1,387	37	76	65.00
66.00	06600	PHYSICAL THERAPY	18,768	0	2,574	69	115	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	173	5	6	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	54	1	1	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,282	0	1,228	33	20	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,462	0	3,348	89	70	73.00
76.00	03020	CARDIAC REHAB	11,735	0	362	10	4	76.00
76.01	03021	BEHAVIORAL HEALTH	15,167	0	1,130	30	21	76.01
76.02	03022	WOUND CARE	3,388	0	1,037	28	27	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,960	0	327	9	1	90.00
91.00	09100	EMERGENCY	13,479	0	5,994	158	68	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	438,027	0	42,459	1,100	1,100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	573	0	2	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,692	0	3,583	96	15	192.00
194.00	07950	MOB	41,053	0	334	9	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	481,345	0	46,378	1,205	1,115	202.00

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		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT	101,460					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,977	10,474				8.00
9.00	00900	HOUSEKEEPING	2,658	0	11,319			9.00
10.00	01000	DIETARY	3,784	0	467	16,736		10.00
11.00	01100	CAFETERIA	2,668	0	329	0	11,809	11.00
13.00	01300	NURSING ADMINISTRATION	1,476	0	182	0	744	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,766	0	341	0	548	16.00
17.00	01700	SOCIAL SERVICE	593	0	73	0	199	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,427	10,474	3,018	16,736	2,933	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,445	0	1,166	0	676	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	204	0	25	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,470	0	1,292	0	1,371	54.00
60.00	06000	LABORATORY	3,893	0	481	0	1,574	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,695	0	333	0	561	65.00
66.00	06600	PHYSICAL THERAPY	5,932	0	732	0	107	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,381	0	417	0	322	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,409	0	174	0	553	73.00
76.00	03020	CARDIAC REHAB	3,706	0	457	0	211	76.00
76.01	03021	BEHAVIORAL HEALTH	6,192	0	764	0	417	76.01
76.02	03022	WOUND CARE	1,383	0	171	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,514	0	310	0	138	90.00
91.00	09100	EMERGENCY	4,256	0	525	0	1,455	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	96,829	10,474	11,257	16,736	11,809	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	504	0	62	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,034	0	0	0	0	192.00
194.00	07950	MOB	93	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	101,460	10,474	11,319	16,736	11,809	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/15/2014 11:03 am

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			13.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	8,275					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,161				16.00
17.00	01700	SOCIAL SERVICE	0	0	3,058			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	837		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,666	457	3,058		148,238	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,075	304	0		43,984	50.00
51.00	05100	RECOVERY ROOM	0	0	0		0	51.00
53.00	05300	ANESTHESIOLOGY	0	167	0		1,074	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,715	0		54,822	54.00
60.00	06000	LABORATORY	0	3,531	0		23,405	60.00
64.00	06400	INTRAVENOUS THERAPY	0	62	0		92	64.00
65.00	06500	RESPIRATORY THERAPY	0	918	0		14,543	65.00
66.00	06600	PHYSICAL THERAPY	0	1,383	0		29,680	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	78	0		262	67.00
68.00	06800	SPEECH PATHOLOGY	0	12	0		68	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	238	0		13,921	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	839	0		10,944	73.00
76.00	03020	CARDIAC REHAB	0	48	0		16,533	76.00
76.01	03021	BEHAVIORAL HEALTH	0	250	0		23,971	76.01
76.02	03022	WOUND CARE	0	325	0		6,359	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	219	17	0		11,495	90.00
91.00	09100	EMERGENCY	2,315	817	0		29,067	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,275	13,161	3,058	0	428,458	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		1,141	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		9,420	192.00
194.00	07950	MOB	0	0	0		41,489	194.00
194.01	07951	MOB	0	0	0		0	194.01
200.00		Cross Foot Adjustments				837	837	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,275	13,161	3,058	837	481,345	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/15/2014 11:03 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2				1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING				5.03
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	148,238		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	43,984		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	1,074		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,822		54.00
60.00	06000	LABORATORY	0	23,405		60.00
64.00	06400	INTRAVENOUS THERAPY	0	92		64.00
65.00	06500	RESPIRATORY THERAPY	0	14,543		65.00
66.00	06600	PHYSICAL THERAPY	0	29,680		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	262		67.00
68.00	06800	SPEECH PATHOLOGY	0	68		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,921		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,944		73.00
76.00	03020	CARDIAC REHAB	0	16,533		76.00
76.01	03021	BEHAVIORAL HEALTH	0	23,971		76.01
76.02	03022	WOUND CARE	0	6,359		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	11,495		90.00
91.00	09100	EMERGENCY	0	29,067		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	428,458		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,141		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,420		192.00
194.00	07950	MOB	0	41,489		194.00
194.01	07951	MOB	0	0		194.01
200.00		Cross Foot Adjustments	0	837		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	481,345		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/15/2014 11:03 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-BLDG 1 (SQUARE FEET)	BLDG & FIXT-BLDG 2 (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	1.02	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	79,744					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	28,586				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	0	51,158			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				80,446		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	5,382,019	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	9,646	7,709	1,937	9,646	477,405	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	132,787	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	0	0	0	159,286	5.03
7.00	00700	OPERATION OF PLANT	18,566	8,330	10,236	18,566	171,857	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,606	1,606	0	1,606	25,265	8.00
9.00	00900	HOUSEKEEPING	1,434	525	909	1,434	161,659	9.00
10.00	01000	DIETARY	2,041	0	2,041	2,041	54,875	10.00
11.00	01100	CAFETERIA	1,439	0	1,439	1,439	57,758	11.00
13.00	01300	NURSING ADMINISTRATION	796	0	796	796	220,918	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,492	180	1,312	1,492	162,657	16.00
17.00	01700	SOCIAL SERVICE	320	0	320	320	58,978	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,178	0	13,178	13,178	871,367	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,095	0	5,095	5,095	200,815	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	110	0	110	110	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,648	0	5,648	5,648	407,174	54.00
60.00	06000	LABORATORY	2,100	2,100	0	2,100	467,701	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,454	0	1,454	1,454	166,740	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,200	31,858	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,824	1,824	0	1,824	95,680	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	760	0	760	760	164,294	73.00
76.00	03020	CARDIAC REHAB	1,999	0	1,999	1,999	62,831	76.00
76.01	03021	BEHAVIORAL HEALTH	3,340	3,340	0	3,340	123,803	76.01
76.02	03022	WOUND CARE	746	746	0	746	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,356	0	1,356	1,356	40,858	90.00
91.00	09100	EMERGENCY	2,296	0	2,296	2,296	432,272	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	77,246	26,360	50,886	80,446	4,748,838	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	272	0	272	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,176	2,176	0	0	633,181	192.00
194.00	07950	MOB	50	50	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	29,433	11,676	88,917	302,751	1,598,359	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.369094	0.408452	1.738086	3.763407	0.296981	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/15/2014 11:03 am

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	DATA PROCESSING (ACCUM. COST)	BILLING, COLLECTION, & ADMITTING (GROSS CHARGES)	
			5A.01	5.01	5A.02	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	-926,697	11,846,242				5.01
5.02	00550	DATA PROCESSING	0	307,822	-331,902	12,441,037		5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	277,488	0	299,195	23,557,800	5.03
7.00	00700	OPERATION OF PLANT	0	675,577	0	728,425	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	50,728	0	54,696	0	8.00
9.00	00900	HOUSEKEEPING	0	234,196	0	252,516	0	9.00
10.00	01000	DIETARY	0	125,346	0	135,151	0	10.00
11.00	01100	CAFETERIA	0	90,752	0	97,851	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	298,389	0	321,731	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	245,241	0	264,425	0	16.00
17.00	01700	SOCIAL SERVICE	0	78,371	0	84,502	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	208,072	0	224,349	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,261,155	0	1,359,811	805,542	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	343,574	0	370,451	535,458	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	4,667	0	5,032	295,251	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,119,433	0	1,207,003	6,572,447	54.00
60.00	06000	LABORATORY	0	1,019,112	0	1,098,834	6,227,900	60.00
64.00	06400	INTRAVENOUS THERAPY	0	6,090	0	6,566	109,519	64.00
65.00	06500	RESPIRATORY THERAPY	0	354,169	0	381,875	1,618,313	65.00
66.00	06600	PHYSICAL THERAPY	0	657,404	0	708,831	2,438,748	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	44,072	0	47,520	137,875	67.00
68.00	06800	SPEECH PATHOLOGY	0	13,701	0	14,773	20,678	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	313,546	0	338,074	419,838	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	855,102	0	921,994	1,479,716	73.00
76.00	03020	CARDIAC REHAB	0	92,440	0	99,671	85,260	76.00
76.01	03021	BEHAVIORAL HEALTH	0	288,572	0	311,146	440,435	76.01
76.02	03022	WOUND CARE	0	264,888	0	285,609	574,014	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	83,471	0	90,001	29,358	90.00
91.00	09100	EMERGENCY	0	1,531,979	0	1,651,824	1,441,042	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-926,697	10,845,357	-331,902	11,361,856	23,231,394	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	573	0	618	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	915,110	0	986,696	326,406	192.00
194.00	07950	MOB	0	85,202	0	91,867	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		926,697		331,902	307,177	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.078227		0.026678	0.013039	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		46,378		1,205	1,115	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.003915		0.000097	0.000047	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/15/2014 11:03 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT	54,732					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,606	1,170				8.00
9.00	00900	HOUSEKEEPING	1,434	0	49,466			9.00
10.00	01000	DIETARY	2,041	0	2,041	1,170		10.00
11.00	01100	CAFETERIA	1,439	0	1,439	0	3,507,946	11.00
13.00	01300	NURSING ADMINISTRATION	796	0	796	0	220,918	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,492	0	1,492	0	162,657	16.00
17.00	01700	SOCIAL SERVICE	320	0	320	0	58,978	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,178	1,170	13,178	1,170	871,367	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,095	0	5,095	0	200,815	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	110	0	110	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,648	0	5,648	0	407,174	54.00
60.00	06000	LABORATORY	2,100	0	2,100	0	467,701	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,454	0	1,454	0	166,740	65.00
66.00	06600	PHYSICAL THERAPY	3,200	0	3,200	0	31,858	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,824	0	1,824	0	95,680	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	760	0	760	0	164,294	73.00
76.00	03020	CARDIAC REHAB	1,999	0	1,999	0	62,831	76.00
76.01	03021	BEHAVIORAL HEALTH	3,340	0	3,340	0	123,803	76.01
76.02	03022	WOUND CARE	746	0	746	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,356	0	1,356	0	40,858	90.00
91.00	09100	EMERGENCY	2,296	0	2,296	0	432,272	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	52,234	1,170	49,194	1,170	3,507,946	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	272	0	272	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,176	0	0	0	0	192.00
194.00	07950	MOB	50	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	747,858	78,099	278,847	178,150	128,235	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.663999	66.751282	5.637145	152.264957	0.036556	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	101,460	10,474	11,319	16,736	11,809	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.853760	8.952137	0.228824	14.304274	0.003366	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/15/2014 11:03 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			13.00	16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,545,312					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,231,394				16.00
17.00	01700	SOCIAL SERVICE	0	0	1,170			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	871,367	805,542	1,170			30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	200,815	535,458	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	295,251	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,572,447	0	0		54.00
60.00	06000	LABORATORY	0	6,227,900	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	109,519	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,618,313	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,438,748	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	137,875	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	20,678	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	419,838	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,479,716	0	0		73.00
76.00	03020	CARDIAC REHAB	0	85,260	0	0		76.00
76.01	03021	BEHAVIORAL HEALTH	0	440,435	0	0		76.01
76.02	03022	WOUND CARE	0	574,014	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	40,858	29,358	0	0		90.00
91.00	09100	EMERGENCY	432,272	1,441,042	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,545,312	23,231,394	1,170	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	MOB	0	0	0	0		194.00
194.01	07951	MOB	0	0	0	0		194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	353,754	306,223	95,088	230,334		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.228921	0.013181	81.271795	2,303.340000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,275	13,161	3,058	837		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005355	0.000567	2.613675	8.370000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/15/2014 11:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,254,224		2,254,224	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	546,025		546,025	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	245,365		245,365	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,535,445		1,535,445	0	0	54.00
60.00	06000	LABORATORY	1,349,074		1,349,074	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	9,613		9,613	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	468,653	0	468,653	0	0	65.00
66.00	06600	PHYSICAL THERAPY	854,614	0	854,614	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,403	0	52,403	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,710	0	15,710	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	396,804		396,804	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,006,064		1,006,064	0	0	73.00
76.00	03020	CARDIAC REHAB	145,446		145,446	0	0	76.00
76.01	03021	BEHAVIORAL HEALTH	399,987		399,987	0	0	76.01
76.02	03022	WOUND CARE	322,677		322,677	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	130,191		130,191	0	0	90.00
91.00	09100	EMERGENCY	1,892,751		1,892,751	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	200,193		200,193		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,825,239	0	11,825,239	0	0	200.00
201.00		Less Observation Beds	200,193		200,193		0	201.00
202.00		Total (see instructions)	11,625,046	0	11,625,046	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/15/2014 11:03 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	644,942		644,942			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,652	514,806	535,458	1.019735	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	12,546	282,705	295,251	0.831039	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109,367	6,463,080	6,572,447	0.233618	0.000000	54.00
60.00	06000	LABORATORY	300,478	5,927,422	6,227,900	0.216618	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	30,317	79,202	109,519	0.087775	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	275,169	1,343,144	1,618,313	0.289594	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	206,643	2,232,105	2,438,748	0.350431	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	96,635	41,240	137,875	0.380076	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	819	19,859	20,678	0.759745	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	92,151	327,687	419,838	0.945136	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	148,531	1,331,185	1,479,716	0.679903	0.000000	73.00
76.00	03020	CARDIAC REHAB	6,138	79,122	85,260	1.705911	0.000000	76.00
76.01	03021	BEHAVIORAL HEALTH	0	440,435	440,435	0.908164	0.000000	76.01
76.02	03022	WOUND CARE	0	574,014	574,014	0.562141	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	29,358	29,358	4.434600	0.000000	90.00
91.00	09100	EMERGENCY	6,800	1,434,242	1,441,042	1.313460	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,500	159,100	160,600	1.246532	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	1,952,688	21,278,706	23,231,394			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,952,688	21,278,706	23,231,394			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/15/2014 11:03 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
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	CARDIAC REHAB	0.000000	76.00
76.01	03021	BEHAVIORAL HEALTH	0.000000	76.01
76.02	03022	WOUND CARE	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part II Date/Time Prepared: 11/15/2014 11:03 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	43,984	535,458	0.082143	16,588	1,363	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1,074	295,251	0.003638	10,710	39	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,822	6,572,447	0.008341	70,790	590	54.00
60.00	06000	LABORATORY	23,405	6,227,900	0.003758	176,197	662	60.00
64.00	06400	INTRAVENOUS THERAPY	92	109,519	0.000840	18,969	16	64.00
65.00	06500	RESPIRATORY THERAPY	14,543	1,618,313	0.008987	156,819	1,409	65.00
66.00	06600	PHYSICAL THERAPY	29,680	2,438,748	0.012170	29,280	356	66.00
67.00	06700	OCCUPATIONAL THERAPY	262	137,875	0.001900	13,010	25	67.00
68.00	06800	SPEECH PATHOLOGY	68	20,678	0.003289	218	1	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,921	419,838	0.033158	56,030	1,858	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,944	1,479,716	0.007396	70,855	524	73.00
76.00	03020	CARDIAC REHAB	16,533	85,260	0.193913	906	176	76.00
76.01	03021	BEHAVIORAL HEALTH	23,971	440,435	0.054426	0	0	76.01
76.02	03022	WOUND CARE	6,359	574,014	0.011078	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,495	29,358	0.391546	0	0	90.00
91.00	09100	EMERGENCY	29,067	1,441,042	0.020171	2,000	40	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	27,049	160,600	0.168425	1,500	253	92.00
200.00		Total (lines 50-199)	307,269	22,586,452		623,872	7,312	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/15/2014 11:03 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	230,334	0	0	0	230,334	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03021	BEHAVIORAL HEALTH	0	0	0	0	0	76.01
76.02	03022	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	230,334	0	0	0	230,334	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/15/2014 11:03 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	535,458	0.000000	0.000000	16,588	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	295,251	0.780129	0.000000	10,710	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,572,447	0.000000	0.000000	70,790	54.00
60.00	06000	LABORATORY	0	6,227,900	0.000000	0.000000	176,197	60.00
64.00	06400	INTRAVENOUS THERAPY	0	109,519	0.000000	0.000000	18,969	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,618,313	0.000000	0.000000	156,819	65.00
66.00	06600	PHYSICAL THERAPY	0	2,438,748	0.000000	0.000000	29,280	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	137,875	0.000000	0.000000	13,010	67.00
68.00	06800	SPEECH PATHOLOGY	0	20,678	0.000000	0.000000	218	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	419,838	0.000000	0.000000	56,030	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,479,716	0.000000	0.000000	70,855	73.00
76.00	03020	CARDIAC REHAB	0	85,260	0.000000	0.000000	906	76.00
76.01	03021	BEHAVIORAL HEALTH	0	440,435	0.000000	0.000000	0	76.01
76.02	03022	WOUND CARE	0	574,014	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	29,358	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	1,441,042	0.000000	0.000000	2,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	160,600	0.000000	0.000000	1,500	92.00
200.00		Total (lines 50-199)	0	22,586,452			623,872	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/15/2014 11:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	8,355	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	CARDIAC REHAB	0	0	0		76.00
76.01	03021	BEHAVIORAL HEALTH	0	0	0		76.01
76.02	03022	WOUND CARE	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	8,355	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/15/2014 11:03 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	1.019735	0	243,813	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.831039	0	138,767	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233618	0	2,761,588	0	0	54.00
60.00	06000	LABORATORY	0.216618	0	2,946,588	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.087775	0	33,997	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.289594	0	740,937	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.350431	0	829,300	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.380076	0	11,100	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.759745	0	5,928	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.945136	0	152,511	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.679903	0	677,081	0	0	73.00
76.00	03020	CARDIAC REHAB	1.705911	0	59,452	0	0	76.00
76.01	03021	BEHAVIORAL HEALTH	0.908164	0	425,685	0	0	76.01
76.02	03022	WOUND CARE	0.562141	0	229,245	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4.434600	0	12,310	0	0	90.00
91.00	09100	EMERGENCY	1.313460	0	493,598	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.246532	0	80,139	0	0	92.00
200.00		Subtotal (see instructions)		0	9,842,039	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	9,842,039	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/15/2014 11:03 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	248,625	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	115,321	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	645,157	0	54.00
60.00	06000	LABORATORY	638,284	0	60.00
64.00	06400	INTRAVENOUS THERAPY	2,984	0	64.00
65.00	06500	RESPIRATORY THERAPY	214,571	0	65.00
66.00	06600	PHYSICAL THERAPY	290,612	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,219	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,504	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	144,144	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	460,349	0	73.00
76.00	03020	CARDIAC REHAB	101,420	0	76.00
76.01	03021	BEHAVIORAL HEALTH	386,592	0	76.01
76.02	03022	WOUND CARE	128,868	0	76.02
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	54,590	0	90.00
91.00	09100	EMERGENCY	648,321	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	99,896	0	92.00
200.00		Subtotal (see instructions)	4,188,457	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	4,188,457	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141306 | Component CCN: 14Z306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V | Date/Time Prepared: 11/15/2014 11:03 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	1.019735	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.831039	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233618	0	0	0	0	54.00
60.00	06000	LABORATORY	0.216618	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.087775	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.289594	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.350431	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.380076	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.759745	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.945136	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.679903	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	1.705911	0	0	0	0	76.00
76.01	03021	BEHAVIORAL HEALTH	0.908164	0	0	0	0	76.01
76.02	03022	WOUND CARE	0.562141	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4.434600	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.313460	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.246532	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141306 | Component CCN: 14Z306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V | Date/Time Prepared: 11/15/2014 11:03 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
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	76.00
76.01	03021	BEHAVIORAL HEALTH	0	0	76.01
76.02	03022	WOUND CARE	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/15/2014 11:03 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)	1,170	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	559	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	457	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	294	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)	294	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	12	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)	11	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	368	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)	273	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)	274	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	132.03	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.03	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,254,224	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	1,584	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)	1,452	25.00
26.00	Total swing-bed cost (see instructions)	1,157,086	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,097,138	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 27 minus line 36)	1,097,138	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)	1,962.67	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	722,263	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)	722,263	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/15/2014 11:03 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	0	0	0.00	0	0	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)	250,145	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	972,408	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)	535,809	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	537,772	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,073,581	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)	102	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,962.68	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	200,193	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/15/2014 11:03 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	148,238	1,097,138	0.135113	200,193	27,049	90.00
91.00	Nursing School cost	0	1,097,138	0.000000	200,193	0	91.00
92.00	Allied health cost	0	1,097,138	0.000000	200,193	0	92.00
93.00	All other Medical Education	0	1,097,138	0.000000	200,193	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/15/2014 11:03 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		315,271		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.019735	16,588	16,915	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.831039	10,710	8,900	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233618	70,790	16,538	54.00
60.00	06000	LABORATORY	0.216618	176,197	38,167	60.00
64.00	06400	INTRAVENOUS THERAPY	0.087775	18,969	1,665	64.00
65.00	06500	RESPIRATORY THERAPY	0.289594	156,819	45,414	65.00
66.00	06600	PHYSICAL THERAPY	0.350431	29,280	10,261	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.380076	13,010	4,945	67.00
68.00	06800	SPEECH PATHOLOGY	0.759745	218	166	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.945136	56,030	52,956	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.679903	70,855	48,175	73.00
76.00	03020	CARDIAC REHAB	1.705911	906	1,546	76.00
76.01	03021	BEHAVIORAL HEALTH	0.908164	0	0	76.01
76.02	03022	WOUND CARE	0.562141	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	4.434600	0	0	90.00
91.00	09100	EMERGENCY	1.313460	2,000	2,627	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.246532	1,500	1,870	92.00
200.00		Total (sum of lines 50-94 and 96-98)		623,872	250,145	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)		623,872		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141306 | Component CCN: 14Z306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/15/2014 11:03 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
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.019735	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.831039	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233618	18,474	4,316	54.00
60.00	06000	LABORATORY	0.216618	66,180	14,336	60.00
64.00	06400	INTRAVENOUS THERAPY	0.087775	3,883	341	64.00
65.00	06500	RESPIRATORY THERAPY	0.289594	79,242	22,948	65.00
66.00	06600	PHYSICAL THERAPY	0.350431	154,195	54,035	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.380076	71,235	27,075	67.00
68.00	06800	SPEECH PATHOLOGY	0.759745	601	457	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.945136	23,109	21,841	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.679903	60,290	40,991	73.00
76.00	03020	CARDIAC REHAB	1.705911	4,502	7,680	76.00
76.01	03021	BEHAVIORAL HEALTH	0.908164	0	0	76.01
76.02	03022	WOUND CARE	0.562141	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	4.434600	0	0	90.00
91.00	09100	EMERGENCY	1.313460	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.246532	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		481,711	194,020	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)		481,711		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E Part B Date/Time Prepared: 11/15/2014 11:03 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,188,457	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,188,457	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,230,342	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	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)	41,195	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,379,425	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)	2,809,722	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)	2,809,722	30.00
31.00	Primary payer payments	505	31.00
32.00	Subtotal (line 30 minus line 31)	2,809,217	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)	238,213	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	209,627	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	218,204	36.00
37.00	Subtotal (see instructions)	3,018,844	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,018,844	40.00
40.01	Sequestration adjustment (see instructions)	60,377	40.01
41.00	Interim payments	2,990,520	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-32,053	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 11/15/2014 11:03 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		899,235		2,970,303	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	01/24/2014	79,032	01/24/2014	42,799	3.01
3.02		06/20/2014	248,944		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	06/20/2014	22,582	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)		327,976		20,217	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)		1,227,211		2,990,520	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		352,044		32,053	6.02
7.00	Total Medicare program liability (see instructions)		875,167		2,958,467	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141306 | Component CCN: 14Z306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 11/15/2014 11:03 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		1,061,406		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	01/24/2014	77,220		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	06/20/2014	6,410		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)		70,810		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)		1,132,216		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		121,436		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,253,652		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141306	Period: From 07/01/2013 To 06/30/2014	Worksheet E-1 Part II Date/Time Prepared: 11/15/2014 11:03 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	223	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	368	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	457	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	23,231,394	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	40,841	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141306 | Component CCN: 14Z306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-2 | Date/Time Prepared: 11/15/2014 11:03 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)	1,084,317	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 6 and 7, line 202 for Part B) (For CAH, see instructions)	195,960	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	547	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)	1,280,277	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,280,277	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)	1,280,277	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,040	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)	1,279,237	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	RURAL DEMONSTRATION PROJECT	0		16.50
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)	1,279,237	0	19.00
19.01	Sequestration adjustment (see instructions)	25,585	0	19.01
20.00	Interim payments	1,132,216	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	121,436	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: 141306	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part V Date/Time Prepared: 11/15/2014 11:03 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	972,408	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)	972,408	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	982,132	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 physicians' services in a teaching hospital (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)	982,132	19.00
20.00	Deductibles (exclude professional component)	103,681	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	878,451	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	878,451	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	16,565	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	14,577	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	14,920	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	893,028	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	893,028	30.00
30.01	Sequestration adjustment (see instructions)	17,861	30.01
31.00	Interim payments	1,227,211	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	-352,044	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G | Date/Time Prepared: 11/15/2014 11:03 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,343,330	0	0	0	1.00
2.00	Temporary investments	800,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,256,632	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	221,461	0	0	0	7.00
8.00	Prepaid expenses	440,473	0	0	0	8.00
9.00	Other current assets	125,000	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,186,896	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	520,386	0	0	0	12.00
13.00	Land improvements	508,275	0	0	0	13.00
14.00	Accumulated depreciation	-280,412	0	0	0	14.00
15.00	Buildings	3,472,958	0	0	0	15.00
16.00	Accumulated depreciation	-2,645,404	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	2,468,539	0	0	0	19.00
20.00	Accumulated depreciation	-2,090,458	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	4,527,669	0	0	0	23.00
24.00	Accumulated depreciation	-3,777,848	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	2,173,716	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	4,877,421	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,771,932	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	1,973,875	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,745,807	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	14,810,124	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	467,963	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,040,621	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	125,201	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	230,500	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,864,285	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	428,826	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	49,780	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	478,606	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	2,342,891	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	12,467,233				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	12,467,233	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	14,810,124	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-1 | Date/Time Prepared: 11/15/2014 11:03 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		12,059,942		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		215,349				2.00
3.00	Total (sum of line 1 and line 2)		12,275,291		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		12,275,291		0		11.00
12.00	CHANGE IN INTEREST IN NET ASSETS	-191,942		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)		-191,942		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,467,233		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/15/2014 11:03 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	406,652		406,652	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	215,970		215,970	5.00
6.00	Swing bed - NF	22,320		22,320	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)	644,942		644,942	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	644,942		644,942	17.00
18.00	Ancillary services	1,299,446	19,656,006	20,955,452	18.00
19.00	Outpatient services	8,300	1,622,700	1,631,000	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	77,454	2,122,116	2,199,570	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,030,142	23,400,822	25,430,964	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		13,985,812		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		13,985,812		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141306 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-3 | Date/Time Prepared: 11/15/2014 11:03 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	25,430,964	1.00
2.00	Less contractual allowances and discounts on patients' accounts	11,629,677	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,801,287	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	13,985,812	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-184,525	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	134,434	6.00
7.00	Income from investments	28,416	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	0	10.00
11.00	Rebates and refunds of expenses	10,660	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	37,676	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	2,133	16.00
17.00	Revenue from sale of drugs to other than patients	1,178	17.00
18.00	Revenue from sale of medical records and abstracts	5,796	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	28,940	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	150,141	24.00
24.01	GAIN ON DISPOSAL OF ASSETS	2,500	24.01
25.00	Total other income (sum of lines 6-24)	401,874	25.00
26.00	Total (line 5 plus line 25)	217,349	26.00
27.00	SCHOLARSHIP	2,000	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2,000	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	215,349	29.00