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: 141312	Period: From 05/01/2013 To 04/30/2014	Worksheet S Parts I-III Date/Time Prepared: 9/5/2014 1:59 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/5/2014 Time: 1:59 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ROCHELLE COMMUNITY HOSPITAL (141312) for the cost reporting period beginning 05/01/2013 and ending 04/30/2014 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

		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	-248,335	-393,491	-13,831	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-12,614	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-260,949	-393,491	-13,831	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 9/5/2014 1:54 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 900 NORTH 2ND STREET	PO Box:			1.00
2.00	City: ROCHELLE	State: IL	Zip Code: 61068	County: OGLE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ROCHELLE COMMUNITY HOSPITAL	141312	99914	1	05/01/2001	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ROCHELLE COMMUNITY HOSPITAL	14Z312	99914		04/17/1987	N	N	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	05/01/2013	04/30/2014	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.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 9/5/2014 1:54 pm

		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		39.00

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

		Y/N	IME	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: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 9/5/2014 1:54 pm

		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: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 9/5/2014 1:54 pm

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 9/5/2014 1:54 pm

		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	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	188,226	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.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141312	Period: From 05/01/2013 To 04/30/2014	Worksheet S-2 Part I Date/Time Prepared: 9/5/2014 1:54 pm

				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.		Y	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	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)		3,038,006	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)	10/01/2012	12/31/2012	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 9/5/2014 1:54 pm

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	08/22/2014	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 9/5/2014 1:54 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				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.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 9/5/2014 1:54 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	08/22/2014			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.		PRINCIPAL		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HFS Supplemental Information | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-2 Part IX Date/Time Prepared: 9/5/2014 1:54 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 9/5/2014 1:54 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	12	4,380	48,676.00	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)		12	4,380	48,676.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		16	5,840	48,676.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
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)		16				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		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: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 9/5/2014 1:54 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,263	131	1,894			1.00
2.00	HMO and other (see instructions)	123	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	99	0	99			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,362	131	1,993			7.00
8.00	INTENSIVE CARE UNIT	29	12	44			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,391	143	2,037	0.00	170.09	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
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	170.09	27.00
28.00	Observation Bed Days		0	473			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: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 9/5/2014 1:54 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	377	67	659	1.00
2.00	HMO and other (see instructions)			38			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	377	67	659	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
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: 141312	Period: From 05/01/2013 To 04/30/2014	Worksheet S-10 Date/Time Prepared: 9/5/2014 1:54 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.456038	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,182,838	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	7,052,774	6.00
7.00	Medicaid cost (line 1 times line 6)	3,216,333	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)	33,495	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	32,926	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	33,495	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,422,469	145,781	1,568,250	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	648,700	66,482	715,182	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)	648,700	66,482	715,182	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,063,317	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	487,809	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,575,508	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	718,492	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,433,674	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,467,169	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A | Date/Time Prepared: 9/5/2014 1:54 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		653,857	653,857	246,999	900,856	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,028,164	2,028,164	0	2,028,164	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	142,479	3,509,708	3,652,187	0	3,652,187	4.00
5.01	00540	ADMISSIONS	306,894	16,271	323,165	56,851	380,016	5.01
5.02	00560	BUSINESS SERVICES	338,189	393,164	731,353	0	731,353	5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL	1,017,667	2,338,430	3,356,097	-10,599	3,345,498	5.03
7.00	00700	OPERATION OF PLANT	343,172	917,342	1,260,514	0	1,260,514	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	91,148	91,148	0	91,148	8.00
9.00	00900	HOUSEKEEPING	259,456	44,835	304,291	0	304,291	9.00
10.00	01000	DIETARY	278,318	216,440	494,758	-319,037	175,721	10.00
11.00	01100	CAFETERIA	0	0	0	319,037	319,037	11.00
13.00	01300	NURSING ADMINISTRATION	259,794	55,144	314,938	0	314,938	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	88,299	24,484	112,783	0	112,783	14.00
15.00	01500	PHARMACY	223,694	994,283	1,217,977	0	1,217,977	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	361,557	125,517	487,074	0	487,074	16.00
17.00	01700	SOCIAL SERVICE	196,095	24,297	220,392	0	220,392	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,711,659	184,370	1,896,029	350	1,896,379	30.00
31.00	03100	INTENSIVE CARE UNIT	17,597	10,950	28,547	0	28,547	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	736,031	612,653	1,348,684	24	1,348,708	50.00
53.00	05300	ANESTHESIOLOGY	0	219,249	219,249	0	219,249	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	598,385	1,395,674	1,994,059	2,173	1,996,232	54.00
60.00	06000	LABORATORY	782,503	825,059	1,607,562	1,750	1,609,312	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	66,558	66,558	0	66,558	62.00
64.00	06400	INTRAVENOUS THERAPY	181,454	16,314	197,768	56	197,824	64.00
65.00	06500	RESPIRATORY THERAPY	27,720	907,951	935,671	5,956	941,627	65.00
66.00	06600	PHYSICAL THERAPY	10,033	971,223	981,256	0	981,256	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,923	10,923	0	10,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	276,117	276,117	0	276,117	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	17,488	3,090	20,578	0	20,578	90.01
91.00	09100	EMERGENCY	1,157,054	927,691	2,084,745	-1,408	2,083,337	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		202,032	202,032	-202,032	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,055,538	18,062,938	27,118,476	100,120	27,218,596	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	306,096	144,693	450,789	0	450,789	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	432,075	113,196	545,271	-100,120	445,151	194.02
194.03	07953	ASHTON CLINIC	143,980	39,129	183,109	0	183,109	194.03
194.04	07954	340B PHARMACY	0	17,357	17,357	0	17,357	194.04
200.00		TOTAL (SUM OF LINES 118-199)	9,937,689	18,377,313	28,315,002	0	28,315,002	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A | Date/Time Prepared: 9/5/2014 1:54 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-109,558	791,298		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,100,357	927,807		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,310	3,650,877		4.00
5.01	00540	ADMISSIONS	0	380,016		5.01
5.02	00560	BUSINESS SERVICES	0	731,353		5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL	-996,245	2,349,253		5.03
7.00	00700	OPERATION OF PLANT	-1,230	1,259,284		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	91,148		8.00
9.00	00900	HOUSEKEEPING	0	304,291		9.00
10.00	01000	DIETARY	0	175,721		10.00
11.00	01100	CAFETERIA	-124,162	194,875		11.00
13.00	01300	NURSING ADMINISTRATION	-5,210	309,728		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	112,783		14.00
15.00	01500	PHARMACY	0	1,217,977		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,468	478,606		16.00
17.00	01700	SOCIAL SERVICE	0	220,392		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,896,379		30.00
31.00	03100	INTENSIVE CARE UNIT	0	28,547		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,348,708		50.00
53.00	05300	ANESTHESIOLOGY	-217,302	1,947		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-18,000	1,978,232		54.00
60.00	06000	LABORATORY	0	1,609,312		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	66,558		62.00
64.00	06400	INTRAVENOUS THERAPY	0	197,824		64.00
65.00	06500	RESPIRATORY THERAPY	-93,942	847,685		65.00
66.00	06600	PHYSICAL THERAPY	-70,597	910,659		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,923		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	276,117		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC	0	20,578		90.01
91.00	09100	EMERGENCY	-473,794	1,609,543		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,220,175	23,998,421		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OCCUPATIONAL HEALTH	0	450,789		194.00
194.01	07951	FOUNDATION	0	0		194.01
194.02	07952	PHYSICIANS CLINICS	0	445,151		194.02
194.03	07953	ASHTON CLINIC	0	183,109		194.03
194.04	07954	340B PHARMACY	0	17,357		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-3,220,175	25,094,827		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet Non-CMS W | Date/Time Prepared: 9/5/2014 1:54 pm

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01	ADMISSIONS	00540		5.01
5.02	BUSINESS SERVICES	00560		5.02
5.03	OTHER ADMINISTRATIVE AND GENERAL	00561		5.03
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	06200		62.00
64.00	INTRAVENOUS THERAPY	06400		64.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	09000		90.00
90.01	CLINIC	09001		90.01
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
194.00	OCCUPATIONAL HEALTH	07950		194.00
194.01	FOUNDATION	07951		194.01
194.02	PHYSICIANS CLINICS	07952		194.02
194.03	ASHTON CLINIC	07953		194.03
194.04	340B PHARMACY	07954		194.04
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-6 | Date/Time Prepared: 9/5/2014 1:54 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	47,936		1.00
	TOTALS		0	47,936		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	179,469	139,568		1.00
	TOTALS		179,469	139,568		
	C - RECEPTIONIST-NURSING					
1.00	ADMISSIONS	5.01	56,851	0		1.00
2.00	RESPIRATORY THERAPY	65.00	43,269	0		2.00
	TOTALS		100,120	0		
	D - IV PUMP					
1.00	ADULTS & PEDIATRICS	30.00	0	350		1.00
2.00	EMERGENCY	91.00	0	342		2.00
3.00	INTRAVENOUS THERAPY	64.00	0	56		3.00
4.00	OPERATING ROOM	50.00	0	24		4.00
5.00	RESPIRATORY THERAPY	65.00	0	24		5.00
	TOTALS		0	796		
	E - FITNESS CENTER					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	37,337		1.00
	TOTALS		0	37,337		
	F - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	199,063		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,173		2.00
	TOTALS		0	201,236		
	G - EKG'S					
1.00	LABORATORY	60.00	1,750	0		1.00
	TOTALS		1,750	0		
500.00	Grand Total: Increases		281,339	426,873		500.00

RECLASSIFICATIONS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-6 | Date/Time Prepared: 9/5/2014 1:54 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	47,936	12		1.00
	TOTALS		0	47,936			
	B - CAFETERIA						
1.00	DIETARY	10.00	179,469	139,568	0		1.00
	TOTALS		179,469	139,568			
	C - RECEPTIONIST-NURSING						
1.00	PHYSICIANS CLINICS	194.02	100,120	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		100,120	0			
	D - IV PUMP						
1.00	INTEREST EXPENSE	113.00	0	796	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		0	796			
	E - FITNESS CENTER						
1.00	RESPIRATORY THERAPY	65.00	0	37,337	0		1.00
	TOTALS		0	37,337			
	F - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	201,236	11		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	201,236			
	G - EKG'S						
1.00	EMERGENCY	91.00	1,750	0	0		1.00
	TOTALS		1,750	0			
500.00	Grand Total: Decreases		281,339	426,873			500.00

RECLASSIFICATIONS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 9/5/2014 1:54 pm

	Increases			Decreases			
	Cost Center	Line #	Salary	Cost Center	Line #	Salary	
	2.00	3.00	4.00	6.00	7.00	8.00	
	A - INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	1.00
	TOTALS		0	TOTALS		0	
	B - CAFETERIA						
1.00	CAFETERIA	11.00	179,469	DIETARY	10.00	179,469	1.00
	TOTALS		179,469	TOTALS		179,469	
	C - RECEPTIONIST-NURSING						
1.00	ADMISSIONS	5.01	56,851	PHYSICIANS CLINICS	194.02	100,120	1.00
2.00	RESPIRATORY THERAPY	65.00	43,269		0.00	0	2.00
	TOTALS		100,120	TOTALS		100,120	
	D - IV PUMP						
1.00	ADULTS & PEDIATRICS	30.00	0	INTEREST EXPENSE	113.00	0	1.00
2.00	EMERGENCY	91.00	0		0.00	0	2.00
3.00	INTRAVENOUS THERAPY	64.00	0		0.00	0	3.00
4.00	OPERATING ROOM	50.00	0		0.00	0	4.00
5.00	RESPIRATORY THERAPY	65.00	0		0.00	0	5.00
	TOTALS		0	TOTALS		0	
	E - FITNESS CENTER						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	RESPIRATORY THERAPY	65.00	0	1.00
	TOTALS		0	TOTALS		0	
	F - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	INTEREST EXPENSE	113.00	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0		0.00	0	2.00
	TOTALS		0	TOTALS		0	
	G - EKG'S						
1.00	LABORATORY	60.00	1,750	EMERGENCY	91.00	1,750	1.00
	TOTALS		1,750	TOTALS		1,750	
500.00	Grand Total: Increases		281,339	Grand Total: Decreases		281,339	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 9/5/2014 1:54 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,976,289	304,107	0	304,107	0	1.00
2.00	Land Improvements	1,154,439	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,648,968	144,840	0	144,840	175,401	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,060,011	95,377	0	95,377	0	5.00
6.00	Movable Equipment	8,014,565	892,693	0	892,693	0	6.00
7.00	HIT designated Assets	3,424,390	480,601	0	480,601	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,278,662	1,917,618	0	1,917,618	175,401	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	28,278,662	1,917,618	0	1,917,618	175,401	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,280,396	0	1.00
2.00	Land Improvements	1,154,439	0	2.00
3.00	Buildings and Fixtures	11,618,407	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	1,155,388	0	5.00
6.00	Movable Equipment	8,907,258	0	6.00
7.00	HIT designated Assets	3,904,991	0	7.00
8.00	Subtotal (sum of lines 1-7)	30,020,879	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	30,020,879	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 9/5/2014 1:54 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	653,857	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,028,164	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,682,021	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	653,857		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,028,164		2.00
3.00	Total (sum of lines 1-2)	0	2,682,021		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-7 Part III Date/Time Prepared: 9/5/2014 1:54 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	17,208,630	0	17,208,630	0.565622	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,460,859	245,215	13,215,644	0.434378	0	2.00
3.00	Total (sum of lines 1-2)	30,669,489	245,215	30,424,274	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	653,857	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,028,164	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,682,021	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	113,193	47,936	-23,688	0	791,298	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-1,100,357	0	0	0	927,807	2.00
3.00	Total (sum of lines 1-2)	-987,164	47,936	-23,688	0	1,719,105	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-8 | Date/Time Prepared: 9/5/2014 1:54 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-85,870	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,230	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-785,038			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	-124,162	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-8,468	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	-12,787	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-1,096,817	CAP REL COSTS-MVBLE EQUIP	2.00	11	32.00
33.00	CREDENTIALING	B	-10,700	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-8 | Date/Time Prepared: 9/5/2014 1:54 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	FITNESS CENTER	B	-22,280	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.01
33.02	MARKETING EXPENSE	A	-262,175	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.02
33.03	LOBBYING EXPENSE	A	-13,659	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.03
33.04	PROPERTY TAX	A	-23,688	CAP REL COSTS-BLDG & FIXT	1.00	13	33.04
33.05	ASSESSMENT TAX	A	-683,136	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.05
33.06	TELEPHONE SERVICES	A	-1,578	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	TELEPHONE SERVICES	A	-4,295	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.07
33.08	TELEPHONE SERVICES	A	-3,540	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.08
33.09	MISC REVENUE - DEF COMP	B	268	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	MISC REVENUE - EDUCATION	B	-5,210	NURSING ADMINISTRATION	13.00	0	33.10
33.11	RENTAL INCOME - MRI	B	-18,000	RADIOLOGY-DIAGNOSTIC	54.00	0	33.11
33.12	RENTAL INCOME - PHYSICAL THERAPY	B	-57,810	PHYSICAL THERAPY	66.00	0	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,220,175				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: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 9/5/2014 1:54 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	65.00	RESPIRATORY THERAPY	93,942	93,942	0	0	0	1.00
2.00	91.00	EMERGENCY	630,325	425,094	205,231	0	0	2.00
3.00	91.00	EMERGENCY	48,700	48,700	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	217,302	217,302	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			990,269	785,038	205,231		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	65.00	RESPIRATORY THERAPY	0	0	0	93,942		1.00
2.00	91.00	EMERGENCY	0	0	0	425,094		2.00
3.00	91.00	EMERGENCY	0	0	0	48,700		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	217,302		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	785,038		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 9/5/2014 1:54 pm

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.63	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	9,413.66	0.00	5,515.14	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.21	0.00	38.11	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)	38.11	38.11	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					717,415	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)					717,415	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					210,182	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)					927,597	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)					927,597	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					13,910	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					13,910	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					2,055	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					15,965	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					15,965	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 9/5/2014 1:54 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	19.71	0.00	70.88	0.00	90.59	47.00
48.00	Overtime rate (see instructions)	114.32	0.00	57.17	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	2,253.25	0.00	4,052.21	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)	21.76	0.00	78.24	0.00	100.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	452.61	0.00	1,627.39	0.00	2,080.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.21	0.00	38.11	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	34,493	0	62,020	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	2,253	0	4,052	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	1,502	0	2,701	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.)	751	0	1,351	0	2,102	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	927,597		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	15,965		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)	2,102		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)	945,664		63.00
64.00	Total cost of outside supplier services (from your records)	958,451		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	12,787		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	13,910		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,055		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	15,965		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,055		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	2,055		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 9/5/2014 1:54 pm

		Respiratory Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.63	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	11,973.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	59.84	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	29.92	29.92	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		716,494	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)		716,494	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)		716,494	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)		716,494	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		10,921	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		10,921	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		2,055	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		12,976	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		12,976	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 9/5/2014 1:54 pm

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	59.84	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		716,494	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		12,976	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)		14,601	61.00
62.00	Supplies (see instructions)		33,366	62.00
63.00	Total allowance (sum of lines 57-62)		777,437	63.00
64.00	Total cost of outside supplier services (from your records)		740,418	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		10,921	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		2,055	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		12,976	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		2,055	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		2,055	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B Part I Date/Time Prepared: 9/5/2014 1:54 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMISSIONS	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	791,298	791,298				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	927,807		927,807			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,650,877	3,534	816	3,655,227		4.00
5.01	00540	ADMISSIONS	380,016	6,247	2,675	141,493	530,431	5.01
5.02	00560	BUSINESS SERVICES	731,353	8,392	3,021	131,552	0	5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL	2,349,253	198,043	168,920	395,861	0	5.03
7.00	00700	OPERATION OF PLANT	1,259,284	92,990	23,577	133,490	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	91,148	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	304,291	6,205	0	100,926	0	9.00
10.00	01000	DIETARY	175,721	23,673	1,667	38,451	0	10.00
11.00	01100	CAFETERIA	194,875	15,060	0	69,811	0	11.00
13.00	01300	NURSING ADMINISTRATION	309,728	11,053	1,890	101,057	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	112,783	10,370	1,824	34,347	0	14.00
15.00	01500	PHARMACY	1,217,977	7,656	8,966	87,015	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	478,606	14,892	3,281	140,642	0	16.00
17.00	01700	SOCIAL SERVICE	220,392	1,609	492	76,279	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,896,379	87,248	131,635	665,819	29,920	30.00
31.00	03100	INTENSIVE CARE UNIT	28,547	17,511	4,417	6,845	1,146	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,348,708	79,087	245,443	286,308	47,118	50.00
53.00	05300	ANESTHESIOLOGY	1,947	0	768	0	7,463	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,978,232	53,100	206,578	232,765	138,948	54.00
60.00	06000	LABORATORY	1,609,312	21,780	47,754	305,066	96,029	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	66,558	0	0	0	1,123	62.00
64.00	06400	INTRAVENOUS THERAPY	197,824	11,243	6,561	70,584	3,997	64.00
65.00	06500	RESPIRATORY THERAPY	847,685	17,689	4,204	27,614	15,271	65.00
66.00	06600	PHYSICAL THERAPY	910,659	23,810	4,317	3,903	37,243	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,923	0	0	0	7,170	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	276,117	0	0	0	9,687	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	78,806	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	20,578	2,766	492	6,803	146	90.01
91.00	09100	EMERGENCY	1,609,543	50,228	34,468	431,981	56,364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,998,421	764,186	903,766	3,488,612	530,431	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,869	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	450,789	0	8,084	73,842	0	194.00
194.01	07951	FOUNDATION	0	252	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	445,151	21,991	15,711	67,384	0	194.02
194.03	07953	ASHTON CLINIC	183,109	0	246	25,389	0	194.03
194.04	07954	340B PHARMACY	17,357	0	0	0	0	194.04
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)	25,094,827	791,298	927,807	3,655,227	530,431	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B Part I | Date/Time Prepared: 9/5/2014 1:54 pm

		Cost Center Description	BUSINESS SERVICES	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMISSIONS						5.01
5.02	00560	BUSINESS SERVICES	874,318					5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL	0	3,112,077	3,112,077			5.03
7.00	00700	OPERATION OF PLANT	0	1,509,341	213,676	1,723,017		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	91,148	12,904	0	104,052	8.00
9.00	00900	HOUSEKEEPING	0	411,422	58,245	22,177	0	9.00
10.00	01000	DIETARY	0	239,512	33,907	84,610	0	10.00
11.00	01100	CAFETERIA	0	279,746	39,603	53,825	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	423,728	59,987	39,505	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	159,324	22,555	37,061	0	14.00
15.00	01500	PHARMACY	0	1,321,614	187,100	27,364	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	637,421	90,239	53,224	0	16.00
17.00	01700	SOCIAL SERVICE	0	298,772	42,297	5,751	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,972	2,859,973	404,882	311,827	30,293	30.00
31.00	03100	INTENSIVE CARE UNIT	1,876	60,342	8,543	62,583	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	77,120	2,083,784	294,999	282,659	21,577	50.00
53.00	05300	ANESTHESIOLOGY	12,215	22,393	3,170	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	227,437	2,837,060	401,640	189,780	19,552	54.00
60.00	06000	LABORATORY	157,176	2,237,117	316,706	77,844	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,838	69,519	9,842	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	6,543	296,752	42,011	40,181	0	64.00
65.00	06500	RESPIRATORY THERAPY	27,480	939,943	133,067	63,222	0	65.00
66.00	06600	PHYSICAL THERAPY	60,957	1,040,889	147,358	85,098	9,684	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,736	29,829	4,223	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,855	301,659	42,706	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	128,986	207,792	29,417	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	239	31,024	4,392	9,886	0	90.01
91.00	09100	EMERGENCY	95,888	2,278,472	322,561	179,519	22,946	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	874,318	23,780,653	2,926,030	1,626,116	104,052	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,869	689	17,403	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	532,715	75,416	0	0	194.00
194.01	07951	FOUNDATION	0	252	36	902	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	550,237	77,897	78,596	0	194.02
194.03	07953	ASHTON CLINIC	0	208,744	29,552	0	0	194.03
194.04	07954	340B PHARMACY	0	17,357	2,457	0	0	194.04
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)	874,318	25,094,827	3,112,077	1,723,017	104,052	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B Part I | Date/Time Prepared: 9/5/2014 1:54 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMISSIONS						5.01
5.02	00560	BUSINESS SERVICES						5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	491,844					9.00
10.00	01000	DIETARY	24,467	382,496				10.00
11.00	01100	CAFETERIA	15,565	0	388,739			11.00
13.00	01300	NURSING ADMINISTRATION	11,424	0	9,997	544,641		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,717	0	8,166	0	237,823	14.00
15.00	01500	PHARMACY	7,913	0	7,975	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,391	0	29,113	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,663	0	8,967	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	90,173	294,907	112,180	260,398	0	30.00
31.00	03100	INTENSIVE CARE UNIT	18,098	9,860	992	2,642	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	81,738	21,171	36,821	90,143	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,880	0	37,203	0	0	54.00
60.00	06000	LABORATORY	22,511	0	59,524	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	11,619	21,706	8,127	21,403	0	64.00
65.00	06500	RESPIRATORY THERAPY	18,282	0	4,045	8,823	0	65.00
66.00	06600	PHYSICAL THERAPY	24,609	0	305	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	237,823	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	2,859	0	1,107	1,528	0	90.01
91.00	09100	EMERGENCY	51,913	34,852	64,217	159,704	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	463,822	382,496	388,739	544,641	237,823	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,033	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	261	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	22,728	0	0	0	0	194.02
194.03	07953	ASHTON CLINIC	0	0	0	0	0	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
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)	491,844	382,496	388,739	544,641	237,823	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B Part I | Date/Time Prepared: 9/5/2014 1:54 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMISSIONS						5.01
5.02	00560	BUSINESS SERVICES						5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,551,966					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	825,388				16.00
17.00	01700	SOCIAL SERVICE	0	0	357,450			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	176,074	349,335	4,890,042	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	702	8,115	171,877	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	49,243	0	2,962,135	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	25,563	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	154,564	0	3,694,679	0	54.00
60.00	06000	LABORATORY	0	154,390	0	2,868,092	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	79,361	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	26,735	0	468,534	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	31,134	0	1,198,516	0	65.00
66.00	06600	PHYSICAL THERAPY	0	17,936	0	1,325,879	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	271,875	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	344,365	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,551,966	0	0	1,789,175	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	50,796	0	90.01
91.00	09100	EMERGENCY	0	214,610	0	3,328,794	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,551,966	825,388	357,450	23,469,683	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	27,994	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	608,131	0	194.00
194.01	07951	FOUNDATION	0	0	0	1,451	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	729,458	0	194.02
194.03	07953	ASHTON CLINIC	0	0	0	238,296	0	194.03
194.04	07954	340B PHARMACY	0	0	0	19,814	0	194.04
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)	1,551,966	825,388	357,450	25,094,827	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B Part I | Date/Time Prepared: 9/5/2014 1:54 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	ADMISSIONS			5.01
5.02	00560	BUSINESS SERVICES			5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL			5.03
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	4,890,042		30.00
31.00	03100	INTENSIVE CARE UNIT	171,877		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,962,135		50.00
53.00	05300	ANESTHESIOLOGY	25,563		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,694,679		54.00
60.00	06000	LABORATORY	2,868,092		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	79,361		62.00
64.00	06400	INTRAVENOUS THERAPY	468,534		64.00
65.00	06500	RESPIRATORY THERAPY	1,198,516		65.00
66.00	06600	PHYSICAL THERAPY	1,325,879		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	271,875		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	344,365		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,789,175		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
90.01	09001	CLINIC	50,796		90.01
91.00	09100	EMERGENCY	3,328,794		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,469,683		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,994		190.00
194.00	07950	OCCUPATIONAL HEALTH	608,131		194.00
194.01	07951	FOUNDATION	1,451		194.01
194.02	07952	PHYSICIANS CLINICS	729,458		194.02
194.03	07953	ASHTON CLINIC	238,296		194.03
194.04	07954	340B PHARMACY	19,814		194.04
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	25,094,827		202.00

COST ALLOCATION STATISTICS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet Non-CMS W | Date/Time Prepared: 9/5/2014 1:54 pm

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

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B Part II | Date/Time Prepared: 9/5/2014 1:54 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,534	816	4,350	4,350	4.00
5.01	00540	ADMISSIONS	0	6,247	2,675	8,922	168	5.01
5.02	00560	BUSINESS SERVICES	0	8,392	3,021	11,413	157	5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL	0	198,043	168,920	366,963	471	5.03
7.00	00700	OPERATION OF PLANT	0	92,990	23,577	116,567	159	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	6,205	0	6,205	120	9.00
10.00	01000	DIETARY	0	23,673	1,667	25,340	46	10.00
11.00	01100	CAFETERIA	0	15,060	0	15,060	83	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,053	1,890	12,943	120	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,370	1,824	12,194	41	14.00
15.00	01500	PHARMACY	0	7,656	8,966	16,622	104	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,892	3,281	18,173	167	16.00
17.00	01700	SOCIAL SERVICE	0	1,609	492	2,101	91	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	87,248	131,635	218,883	792	30.00
31.00	03100	INTENSIVE CARE UNIT	0	17,511	4,417	21,928	8	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	79,087	245,443	324,530	341	50.00
53.00	05300	ANESTHESIOLOGY	0	0	768	768	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	53,100	206,578	259,678	277	54.00
60.00	06000	LABORATORY	0	21,780	47,754	69,534	363	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	11,243	6,561	17,804	84	64.00
65.00	06500	RESPIRATORY THERAPY	0	17,689	4,204	21,893	33	65.00
66.00	06600	PHYSICAL THERAPY	0	23,810	4,317	28,127	5	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	2,766	492	3,258	8	90.01
91.00	09100	EMERGENCY	0	50,228	34,468	84,696	514	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	764,186	903,766	1,667,952	4,152	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,869	0	4,869	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	8,084	8,084	88	194.00
194.01	07951	FOUNDATION	0	252	0	252	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	21,991	15,711	37,702	80	194.02
194.03	07953	ASHTON CLINIC	0	0	246	246	30	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	791,298	927,807	1,719,105	4,350	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B Part II Date/Time Prepared: 9/5/2014 1:54 pm

		Cost Center Description	ADMISSIONS	BUSINESS SERVICES	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMISSIONS	9,090					5.01
5.02	00560	BUSINESS SERVICES	0	11,570				5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL	0	0	367,434			5.03
7.00	00700	OPERATION OF PLANT	0	0	25,229	141,955		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,524	0	1,524	8.00
9.00	00900	HOUSEKEEPING	0	0	6,877	1,827	0	9.00
10.00	01000	DIETARY	0	0	4,003	6,971	0	10.00
11.00	01100	CAFETERIA	0	0	4,676	4,435	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	7,083	3,255	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,663	3,053	0	14.00
15.00	01500	PHARMACY	0	0	22,091	2,254	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	10,654	4,385	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	4,994	474	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	514	647	47,799	25,692	444	30.00
31.00	03100	INTENSIVE CARE UNIT	20	25	1,009	5,156	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	809	1,019	34,830	23,288	316	50.00
53.00	05300	ANESTHESIOLOGY	128	161	374	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,367	3,020	47,421	15,635	286	54.00
60.00	06000	LABORATORY	1,649	2,078	37,393	6,413	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	19	24	1,162	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	69	86	4,960	3,310	0	64.00
65.00	06500	RESPIRATORY THERAPY	262	363	15,711	5,209	0	65.00
66.00	06600	PHYSICAL THERAPY	640	806	17,398	7,011	142	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	123	155	499	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	166	210	5,042	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,353	1,705	3,473	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	3	3	519	814	0	90.01
91.00	09100	EMERGENCY	968	1,268	38,085	14,790	336	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,090	11,570	345,469	133,972	1,524	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	81	1,434	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	8,904	0	0	194.00
194.01	07951	FOUNDATION	0	0	4	74	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	9,197	6,475	0	194.02
194.03	07953	ASHTON CLINIC	0	0	3,489	0	0	194.03
194.04	07954	340B PHARMACY	0	0	290	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	9,090	11,570	367,434	141,955	1,524	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B Part II | Date/Time Prepared: 9/5/2014 1:54 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMISSIONS						5.01
5.02	00560	BUSINESS SERVICES						5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	15,029					9.00
10.00	01000	DIETARY	748	37,108				10.00
11.00	01100	CAFETERIA	476	0	24,730			11.00
13.00	01300	NURSING ADMINISTRATION	349	0	636	24,386		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	327	0	519	0	18,797	14.00
15.00	01500	PHARMACY	242	0	507	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	470	0	1,852	0	0	16.00
17.00	01700	SOCIAL SERVICE	51	0	570	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,755	28,610	7,139	11,660	0	30.00
31.00	03100	INTENSIVE CARE UNIT	553	957	63	118	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,498	2,054	2,342	4,036	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,677	0	2,367	0	0	54.00
60.00	06000	LABORATORY	688	0	3,787	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	355	2,106	517	958	0	64.00
65.00	06500	RESPIRATORY THERAPY	559	0	257	395	0	65.00
66.00	06600	PHYSICAL THERAPY	752	0	19	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	18,797	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	87	0	70	68	0	90.01
91.00	09100	EMERGENCY	1,586	3,381	4,085	7,151	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,173	37,108	24,730	24,386	18,797	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	154	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	8	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	694	0	0	0	0	194.02
194.03	07953	ASHTON CLINIC	0	0	0	0	0	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	15,029	37,108	24,730	24,386	18,797	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B Part II | Date/Time Prepared: 9/5/2014 1:54 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMISSIONS						5.01
5.02	00560	BUSINESS SERVICES						5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	41,820					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,701				16.00
17.00	01700	SOCIAL SERVICE	0	0	8,281			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	7,616	8,093	360,644	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	30	188	30,055	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,130	0	398,193	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,431	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,685	0	339,413	0	54.00
60.00	06000	LABORATORY	0	6,678	0	128,583	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	1,205	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	1,156	0	31,405	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,347	0	46,029	0	65.00
66.00	06600	PHYSICAL THERAPY	0	776	0	55,676	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	19,574	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,418	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,820	0	0	48,351	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	4,830	0	90.01
91.00	09100	EMERGENCY	0	9,283	0	166,143	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,820	35,701	8,281	1,636,950	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	6,538	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	17,076	0	194.00
194.01	07951	FOUNDATION	0	0	0	338	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	54,148	0	194.02
194.03	07953	ASHTON CLINIC	0	0	0	3,765	0	194.03
194.04	07954	340B PHARMACY	0	0	0	290	0	194.04
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)	41,820	35,701	8,281	1,719,105	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B Part II | Date/Time Prepared: 9/5/2014 1:54 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	ADMISSIONS			5.01
5.02	00560	BUSINESS SERVICES			5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL			5.03
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	360,644		30.00
31.00	03100	INTENSIVE CARE UNIT	30,055		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	398,193		50.00
53.00	05300	ANESTHESIOLOGY	1,431		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	339,413		54.00
60.00	06000	LABORATORY	128,583		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,205		62.00
64.00	06400	INTRAVENOUS THERAPY	31,405		64.00
65.00	06500	RESPIRATORY THERAPY	46,029		65.00
66.00	06600	PHYSICAL THERAPY	55,676		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,574		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,418		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,351		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
90.01	09001	CLINIC	4,830		90.01
91.00	09100	EMERGENCY	166,143		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,636,950		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,538		190.00
194.00	07950	OCCUPATIONAL HEALTH	17,076		194.00
194.01	07951	FOUNDATION	338		194.01
194.02	07952	PHYSICIANS CLINICS	54,148		194.02
194.03	07953	ASHTON CLINIC	3,765		194.03
194.04	07954	340B PHARMACY	290		194.04
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	1,719,105		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B-1 | Date/Time Prepared: 9/5/2014 1:54 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMISSIONS (GROSS REVENUE)	BUSINESS SERVICES (GROSS REVENUE)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	75,241					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		849,430				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	336	747	9,396,726			4.00
5.01	00540	ADMISSIONS	594	2,449	363,745	51,464,276		5.01
5.02	00560	BUSINESS SERVICES	798	2,766	338,189	0	51,826,994	5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL	18,831	154,650	1,017,667	0	0	5.03
7.00	00700	OPERATION OF PLANT	8,842	21,585	343,172	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	590	0	259,456	0	0	9.00
10.00	01000	DIETARY	2,251	1,526	98,849	0	0	10.00
11.00	01100	CAFETERIA	1,432	0	179,469	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,051	1,730	259,794	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	986	1,670	88,299	0	0	14.00
15.00	01500	PHARMACY	728	8,209	223,694	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,416	3,004	361,557	0	0	16.00
17.00	01700	SOCIAL SERVICE	153	450	196,095	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,296	120,515	1,711,659	2,902,878	2,902,878	30.00
31.00	03100	INTENSIVE CARE UNIT	1,665	4,044	17,597	111,227	111,227	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,520	224,711	736,031	4,571,433	4,571,433	50.00
53.00	05300	ANESTHESIOLOGY	0	703	0	724,068	724,068	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,049	189,127	598,385	13,481,909	13,481,909	54.00
60.00	06000	LABORATORY	2,071	43,720	784,253	9,316,888	9,316,888	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	108,971	108,971	62.00
64.00	06400	INTRAVENOUS THERAPY	1,069	6,007	181,454	387,838	387,838	64.00
65.00	06500	RESPIRATORY THERAPY	1,682	3,849	70,989	1,481,612	1,628,915	65.00
66.00	06600	PHYSICAL THERAPY	2,264	3,952	10,033	3,613,352	3,613,352	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	695,683	695,683	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	939,855	939,855	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,645,901	7,645,901	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	263	450	17,488	14,156	14,156	90.01
91.00	09100	EMERGENCY	4,776	31,556	1,110,523	5,468,505	5,683,920	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	72,663	827,420	8,968,398	51,464,276	51,826,994	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	463	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	7,401	189,831	0	0	194.00
194.01	07951	FOUNDATION	24	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	2,091	14,384	173,228	0	0	194.02
194.03	07953	ASHTON CLINIC	0	225	65,269	0	0	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
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)	791,298	927,807	3,655,227	530,431	874,318	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.516846	1.092270	0.388989	0.010307	0.016870	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,350	9,090	11,570	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000463	0.000177	0.000223	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B-1 | Date/Time Prepared: 9/5/2014 1:54 pm

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.03	5.03	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMISSIONS						5.01
5.02	00560	BUSINESS SERVICES						5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL	-3,112,077	21,982,750				5.03
7.00	00700	OPERATION OF PLANT	0	1,509,341	45,840			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	91,148	0	140,993		8.00
9.00	00900	HOUSEKEEPING	0	411,422	590	0	45,250	9.00
10.00	01000	DIETARY	0	239,512	2,251	0	2,251	10.00
11.00	01100	CAFETERIA	0	279,746	1,432	0	1,432	11.00
13.00	01300	NURSING ADMINISTRATION	0	423,728	1,051	0	1,051	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	159,324	986	0	986	14.00
15.00	01500	PHARMACY	0	1,321,614	728	0	728	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	637,421	1,416	0	1,416	16.00
17.00	01700	SOCIAL SERVICE	0	298,772	153	0	153	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,859,973	8,296	41,049	8,296	30.00
31.00	03100	INTENSIVE CARE UNIT	0	60,342	1,665	0	1,665	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,083,784	7,520	29,237	7,520	50.00
53.00	05300	ANESTHESIOLOGY	0	22,393	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,837,060	5,049	26,493	5,049	54.00
60.00	06000	LABORATORY	0	2,237,117	2,071	0	2,071	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	69,519	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	296,752	1,069	0	1,069	64.00
65.00	06500	RESPIRATORY THERAPY	0	939,943	1,682	0	1,682	65.00
66.00	06600	PHYSICAL THERAPY	0	1,040,889	2,264	13,122	2,264	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	29,829	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	301,659	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	207,792	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	31,024	263	0	263	90.01
91.00	09100	EMERGENCY	0	2,278,472	4,776	31,092	4,776	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,112,077	20,668,576	43,262	140,993	42,672	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,869	463	0	463	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	532,715	0	0	0	194.00
194.01	07951	FOUNDATION	0	252	24	0	24	194.01
194.02	07952	PHYSICIANS CLINICS	0	550,237	2,091	0	2,091	194.02
194.03	07953	ASHTON CLINIC	0	208,744	0	0	0	194.03
194.04	07954	340B PHARMACY	0	17,357	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		3,112,077	1,723,017	104,052	491,844	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.141569	37.587631	0.737994	10.869481	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		367,434	141,955	1,524	15,029	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.016715	3.096750	0.010809	0.332133	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B-1 | Date/Time Prepared: 9/5/2014 1:54 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMISSIONS						5.01
5.02	00560	BUSINESS SERVICES						5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	10,009					10.00
11.00	01100	CAFETERIA	0	10,188				11.00
13.00	01300	NURSING ADMINISTRATION	0	262	112,960			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	214	0	100		14.00
15.00	01500	PHARMACY	0	209	0	0	947,187	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	763	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	235	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,717	2,940	54,007	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	258	26	548	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	554	965	18,696	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	975	0	0	0	54.00
60.00	06000	LABORATORY	0	1,560	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	568	213	4,439	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	106	1,830	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	100	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	947,187	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	29	317	0	0	90.01
91.00	09100	EMERGENCY	912	1,683	33,123	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,009	10,188	112,960	100	947,187	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	0	0	194.02
194.03	07953	ASHTON CLINIC	0	0	0	0	0	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
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)	382,496	388,739	544,641	237,823	1,551,966	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	38.215206	38.156557	4.821539	2,378.230000	1.638500	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	37,108	24,730	24,386	18,797	41,820	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.707463	2.427366	0.215882	187.970000	0.044152	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B-1 | Date/Time Prepared: 9/5/2014 1:54 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			16.00	17.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540	ADMISSIONS				5.01
5.02	00560	BUSINESS SERVICES				5.02
5.03	00561	OTHER ADMINISTRATIVE AND GENERAL				5.03
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	99,999			16.00
17.00	01700	SOCIAL SERVICE	0	1,938		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	21,332	1,894		30.00
31.00	03100	INTENSIVE CARE UNIT	85	44		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	5,966	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,726	0		54.00
60.00	06000	LABORATORY	18,705	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	3,239	0		64.00
65.00	06500	RESPIRATORY THERAPY	3,772	0		65.00
66.00	06600	PHYSICAL THERAPY	2,173	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC	0	0		90.01
91.00	09100	EMERGENCY	26,001	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	99,999	1,938		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0		194.00
194.01	07951	FOUNDATION	0	0		194.01
194.02	07952	PHYSICIANS CLINICS	0	0		194.02
194.03	07953	ASHTON CLINIC	0	0		194.03
194.04	07954	340B PHARMACY	0	0		194.04
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)	825,388	357,450		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.253963	184.442724		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	35,701	8,281		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.357014	4.272962		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet C Part I Date/Time Prepared: 9/5/2014 1:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,890,042		4,890,042	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	171,877		171,877	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,962,135		2,962,135	0	0	50.00
53.00	05300	ANESTHESIOLOGY	25,563		25,563	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,694,679		3,694,679	0	0	54.00
60.00	06000	LABORATORY	2,868,092		2,868,092	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	79,361		79,361	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	468,534		468,534	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,198,516	0	1,198,516	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,325,879	0	1,325,879	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	271,875		271,875	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	344,365		344,365	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,789,175		1,789,175	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	CLINIC	50,796		50,796	0	0	90.01
91.00	09100	EMERGENCY	3,328,794		3,328,794	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	937,954		937,954		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	24,407,637	0	24,407,637	0	0	200.00
201.00		Less Observation Beds	937,954		937,954		0	201.00
202.00		Total (see instructions)	23,469,683	0	23,469,683	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet C Part I Date/Time Prepared: 9/5/2014 1:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,284,331		2,284,331			30.00
31.00	03100	INTENSIVE CARE UNIT	111,227		111,227			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,055,419	3,516,014	4,571,433	0.647966	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	134,250	589,818	724,068	0.035305	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	791,631	12,690,278	13,481,909	0.274047	0.000000	54.00
60.00	06000	LABORATORY	942,032	8,374,856	9,316,888	0.307838	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	56,951	52,020	108,971	0.728276	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	387,838	387,838	1.208066	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	438,381	1,043,231	1,481,612	0.808927	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	162,232	3,451,120	3,613,352	0.366939	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	485,413	210,270	695,683	0.390803	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	694,889	244,966	939,855	0.366402	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,821,154	5,824,747	7,645,901	0.234004	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	CLINIC	0	14,156	14,156	3.588302	0.000000	90.01
91.00	09100	EMERGENCY	136,536	5,331,969	5,468,505	0.608721	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	618,547	618,547	1.516383	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	9,114,446	42,349,830	51,464,276			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,114,446	42,349,830	51,464,276			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet C Part I Date/Time Prepared: 9/5/2014 1:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D Part II Date/Time Prepared: 9/5/2014 1:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	398,193	4,571,433	0.087105	498,703	43,440	50.00
53.00	05300	ANESTHESIOLOGY	1,431	724,068	0.001976	66,252	131	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	339,413	13,481,909	0.025175	398,030	10,020	54.00
60.00	06000	LABORATORY	128,583	9,316,888	0.013801	567,663	7,834	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,205	108,971	0.011058	37,027	409	62.00
64.00	06400	INTRAVENOUS THERAPY	31,405	387,838	0.080975	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	46,029	1,481,612	0.031067	328,393	10,202	65.00
66.00	06600	PHYSICAL THERAPY	55,676	3,613,352	0.015408	100,417	1,547	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,574	695,683	0.028136	373,649	10,513	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,418	939,855	0.005765	539,486	3,110	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,351	7,645,901	0.006324	1,121,099	7,090	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	CLINIC	4,830	14,156	0.341198	0	0	90.01
91.00	09100	EMERGENCY	166,143	5,468,505	0.030382	897	27	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	72,068	618,547	0.116512	0	0	92.00
200.00		Total (lines 50-199)	1,318,319	49,068,718		4,031,616	94,323	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D Part IV | Date/Time Prepared: 9/5/2014 1:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D Part IV Date/Time Prepared: 9/5/2014 1:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,571,433	0.000000	0.000000	498,703	50.00
53.00	05300	ANESTHESIOLOGY	0	724,068	0.000000	0.000000	66,252	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,481,909	0.000000	0.000000	398,030	54.00
60.00	06000	LABORATORY	0	9,316,888	0.000000	0.000000	567,663	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	108,971	0.000000	0.000000	37,027	62.00
64.00	06400	INTRAVENOUS THERAPY	0	387,838	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,481,612	0.000000	0.000000	328,393	65.00
66.00	06600	PHYSICAL THERAPY	0	3,613,352	0.000000	0.000000	100,417	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	695,683	0.000000	0.000000	373,649	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	939,855	0.000000	0.000000	539,486	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,645,901	0.000000	0.000000	1,121,099	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	CLINIC	0	14,156	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	5,468,505	0.000000	0.000000	897	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	618,547	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	49,068,718			4,031,616	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D Part IV | Date/Time Prepared: 9/5/2014 1:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D Part IV | Date/Time Prepared: 9/5/2014 1:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
			23.00	24.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	CLINIC	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D Part V Date/Time Prepared: 9/5/2014 1:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.647966	0	1,259,855	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.035305	0	196,238	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.274047	0	4,420,684	0	0	54.00
60.00	06000	LABORATORY	0.307838	0	3,667,889	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.728276	0	33,237	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1.208066	0	214,641	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.808927	0	517,315	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.366939	0	938,620	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.390803	0	112,683	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.366402	0	68,509	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234004	0	2,548,785	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC	3.588302	0	2,100	0	0	90.01
91.00	09100	EMERGENCY	0.608721	0	1,642,056	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.516383	0	273,651	0	0	92.00
200.00		Subtotal (see instructions)		0	15,896,263	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	15,896,263	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D Part V Date/Time Prepared: 9/5/2014 1:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	816,343	0		50.00
53.00	05300	ANESTHESIOLOGY	6,928	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,211,475	0		54.00
60.00	06000	LABORATORY	1,129,116	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	24,206	0		62.00
64.00	06400	INTRAVENOUS THERAPY	259,300	0		64.00
65.00	06500	RESPIRATORY THERAPY	418,470	0		65.00
66.00	06600	PHYSICAL THERAPY	344,416	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	44,037	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,102	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	596,426	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC	7,535	0		90.01
91.00	09100	EMERGENCY	999,554	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	414,960	0		92.00
200.00		Subtotal (see instructions)	6,297,868	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	6,297,868	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141312 | Component CCN: 14Z312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D Part V Date/Time Prepared: 9/5/2014 1:54 pm

Title XVIII | Swing Beds - SNF

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.647966	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.035305	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.274047	0	0	0	0	54.00
60.00	06000	LABORATORY	0.307838	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.728276	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1.208066	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.808927	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.366939	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.390803	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.366402	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234004	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC	3.588302	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.608721	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.516383	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141312 | Component CCN: 14Z312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D Part V | Date/Time Prepared: 9/5/2014 1:54 pm

Title XVIII | Swing Beds - SNF

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D-1 | Date/Time Prepared: 9/5/2014 1:54 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,466	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,367	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,894	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	99	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,263	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	99	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,890,042	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	196,316	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,693,726	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)	4,693,726	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)	1,982.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,504,516	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,504,516	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D-1 | Date/Time Prepared: 9/5/2014 1:54 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	171,877	44	3,906.30	29	113,283	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,545,348	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,163,147	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	196,316	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	196,316	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)	473	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,982.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	937,954	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D-1 | Date/Time Prepared: 9/5/2014 1:54 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	360,644	4,693,726	0.076835	937,954	72,068	90.00
91.00	Nursing School cost	0	4,693,726	0.000000	937,954	0	91.00
92.00	Allied health cost	0	4,693,726	0.000000	937,954	0	92.00
93.00	All other Medical Education	0	4,693,726	0.000000	937,954	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D-3 | Date/Time Prepared: 9/5/2014 1:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,441,418		30.00
31.00	03100	INTENSIVE CARE UNIT		72,891		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.647966	498,703	323,143	50.00
53.00	05300	ANESTHESIOLOGY	0.035305	66,252	2,339	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.274047	398,030	109,079	54.00
60.00	06000	LABORATORY	0.307838	567,663	174,748	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.728276	37,027	26,966	62.00
64.00	06400	INTRAVENOUS THERAPY	1.208066	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.808927	328,393	265,646	65.00
66.00	06600	PHYSICAL THERAPY	0.366939	100,417	36,847	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.390803	373,649	146,023	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.366402	539,486	197,669	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234004	1,121,099	262,342	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC	3.588302	0	0	90.01
91.00	09100	EMERGENCY	0.608721	897	546	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.516383	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		4,031,616	1,545,348	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)		4,031,616		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D-3

Component CCN: 14Z312 | Date/Time Prepared: 9/5/2014 1:54 pm

Title XVIII | Swing Beds - SNF

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		104,115		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.647966	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.035305	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.274047	5,149	1,411	54.00
60.00	06000	LABORATORY	0.307838	9,056	2,788	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.728276	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1.208066	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.808927	4,355	3,523	65.00
66.00	06600	PHYSICAL THERAPY	0.366939	40,506	14,863	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.390803	11,966	4,676	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.366402	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234004	41,641	9,744	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC	3.588302	0	0	90.01
91.00	09100	EMERGENCY	0.608721	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.516383	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		112,673	37,005	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)		112,673		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141312	Period: From 05/01/2013 To 04/30/2014	Worksheet E Part B Date/Time Prepared: 9/5/2014 1:54 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,297,868	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,297,868	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	6,360,847	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	43,220	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,491,204	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	3,826,423	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,826,423	30.00
31.00	Primary payer payments	5,607	31.00
32.00	Subtotal (line 30 minus line 31)	3,820,816	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)	500,907	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	440,798	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	435,057	36.00
37.00	Subtotal (see instructions)	4,261,614	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)	4,261,614	40.00
40.01	Sequestration adjustment (see instructions)	85,232	40.01
41.00	Interim payments	4,569,873	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-393,491	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet E-1 Part I Date/Time Prepared: 9/5/2014 1:54 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,000,819		4,522,073	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	11/15/2013	97,000	11/15/2013	47,800	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		97,000		47,800	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)		4,097,819		4,569,873	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		248,335		393,491	6.02
7.00	Total Medicare program liability (see instructions)		3,849,484		4,176,382	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: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 9/5/2014 1:54 pm

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

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		243,555		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		243,555		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		12,614		0	6.02
7.00	Total Medicare program liability (see instructions)		230,941		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: 141312	Period: From 05/01/2013 To 04/30/2014	Worksheet E-1 Part II Date/Time Prepared: 9/5/2014 1:54 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	659	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	1,292	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	123	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	1,938	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	51,464,276	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	1,568,250	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	3,038,006	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	2,895,524	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	2,895,524	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	2,909,355	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)	-13,831	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141312 Component CCN: 14Z312	Period: From 05/01/2013 To 04/30/2014	Worksheet E-2 Date/Time Prepared: 9/5/2014 1:54 pm
	Title XVIII	Swing Beds - SNF	

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	198,279	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)	37,375	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	99	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)	235,654	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	235,654	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)	235,654	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	235,654	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)	235,654	0	19.00
19.01	Sequestration adjustment (see instructions)	4,713	0	19.01
20.00	Interim payments	243,555	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	-12,614	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: 141312	Period: From 05/01/2013 To 04/30/2014	Worksheet E-3 Part V Date/Time Prepared: 9/5/2014 1:54 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	4,163,147	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)	4,163,147	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,204,778	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	4,204,778	19.00
20.00	Deductibles (exclude professional component)	321,376	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,883,402	22.00
23.00	Coinsurance	2,368	23.00
24.00	Subtotal (line 22 minus line 23)	3,881,034	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	53,422	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	47,011	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	46,504	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,928,045	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	3,928,045	30.00
30.01	Sequestration adjustment (see instructions)	78,561	30.01
31.00	Interim payments	4,097,819	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	-248,335	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet G | Date/Time Prepared: 9/5/2014 1:54 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,087,288	0	0	0	1.00
2.00	Temporary investments	7,221,565	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,198,909	0	0	0	4.00
5.00	Other receivable	1,969,402	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,348,149	0	0	0	6.00
7.00	Inventory	194,910	0	0	0	7.00
8.00	Prepaid expenses	581,462	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	17,905,387	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,280,395	0	0	0	12.00
13.00	Land improvements	1,154,439	0	0	0	13.00
14.00	Accumulated depreciation	-1,010,781	0	0	0	14.00
15.00	Buildings	12,065,747	0	0	0	15.00
16.00	Accumulated depreciation	-6,618,221	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	1,155,388	0	0	0	19.00
20.00	Accumulated depreciation	-516,547	0	0	0	20.00
21.00	Automobiles and trucks	8,907,258	0	0	0	21.00
22.00	Accumulated depreciation	-6,131,724	0	0	0	22.00
23.00	Major movable equipment	3,904,991	0	0	0	23.00
24.00	Accumulated depreciation	-1,926,672	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	14,264,273	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	520,368	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	898,803	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,419,171	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	33,588,831	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	903,298	0	0	0	37.00
38.00	Salaries, wages, and fees payable	578,053	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	292,740	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	2,154,142	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,928,233	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	4,284,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	641,729	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	4,925,729	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	8,853,962	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	24,734,869				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)	24,734,869	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	33,588,831	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet G-1 | Date/Time Prepared: 9/5/2014 1:54 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		22,183,816		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,551,050				2.00
3.00	Total (sum of line 1 and line 2)		24,734,866		0		3.00
4.00	ROUNDING	3		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)		3		0		10.00
11.00	Subtotal (line 3 plus line 10)		24,734,869		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		24,734,869		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	ROUNDING		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	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 9/5/2014 1:54 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,284,331		2,284,331	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,284,331		2,284,331	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	111,227		111,227	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)	111,227		111,227	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,395,558		2,395,558	17.00
18.00	Ancillary services	6,582,352	36,385,158	42,967,510	18.00
19.00	Outpatient services	136,536	5,964,672	6,101,208	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL REVENUE	6,441	355,382	361,823	27.00
27.01	CLINICS	0	793,424	793,424	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,120,887	43,498,636	52,619,523	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,315,002		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		28,315,002		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141312 | Period: From 05/01/2013 To 04/30/2014 | Worksheet G-3 | Date/Time Prepared: 9/5/2014 1:54 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	52,619,523	1.00
2.00	Less contractual allowances and discounts on patients' accounts	22,111,912	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,507,611	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,315,002	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,192,609	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	85,602	6.00
7.00	Income from investments	0	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	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	124,162	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	8,468	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	75,810	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANT REVENUE	319,483	24.00
24.01	OTHER REVENUE	277,574	24.01
25.00	Total other income (sum of lines 6-24)	891,099	25.00
26.00	Total (line 5 plus line 25)	3,083,708	26.00
27.00	INVESTMENTS	532,658	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	532,658	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,551,050	29.00