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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141322	Period: From 10/01/2011 To 09/30/2012	Worksheet S Parts I-III Date/Time Prepared: 2/20/2013 9:27 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/20/2013 Time: 9:27 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ABRAHAM LINCOLN MEMORIAL HOSPITAL (141322) for the cost reporting period beginning 10/01/2011 and ending 09/30/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-432,713	-717,993	840,194	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	-84,356	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-517,069	-717,993	840,194	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: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 2/13/2013 6:17 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 200 STAHLHUT DRIVE	PO Box:			1.00
2.00	City: LINCOLN	State: IL	Zip Code: 62656	County: LOGAN	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	ABRAHAM LINCOLN MEMORIAL HOSPITAL	141322	99914	1	02/01/2003	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ABRAHAM LINCOLN MEMORIAL HOSPITAL	14Z322	99914		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2011	09/30/2012	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0		23.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141322	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/13/2013 6:17 pm

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	
		1.00	
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.	N	39.00

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

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-2 Part I Date/Time Prepared: 2/13/2013 6:17 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 2/13/2013 6:17 pm

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	132,254	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H058	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: MEMORIAL HEALTH SYSTEM	Contractor's Name: NGS	Contractor's Number: 00131	141.00
142.00	Street: 701 NORTH FIRST STREET	PO Box:		142.00
143.00	City: SPRINGFIELD	State: IL	Zip Code: 62781	143.00

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

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

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

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							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)						905,925	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 2/13/2013 6:17 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)	Y			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		
		Description	Y/N	Date	
		0	1.00	2.00	
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	01/11/2013	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		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		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		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 2/13/2013 6:17 pm

		Description	Part A Y/N	Part A Date		
		0	1.00	2.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N			21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				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?	Y		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.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-2 Part II Date/Time Prepared: 2/13/2013 6:17 pm

		Part B					
		Y/N	Date				
		3.00	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)	Y	01/11/2013				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N					17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N					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					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					20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N					21.00
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		SENIOR MANAGING CONSULTANT				41.00
42.00	Enter the employer/company name of the cost report preparer.						42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.						43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 2/13/2013 6:17 pm

	Cost Center Description	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours		
		1.00	2.00	3.00	4.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,150	85,742.00		1.00
2.00	HMO						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	85,742.00		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	43.00					13.00
14.00	Total (see instructions)		25	9,150	85,742.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 2/13/2013 6:17 pm

	Cost Center Description	I/P Days / O/P Visits / Trips					
		Title V	Title XVIII	Title XIX	Total All Patients		
		5.00	6.00	7.00	8.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	2,260	568	3,462		1.00
2.00	HMO		70	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	0	775	0	775		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	30		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	3,035	568	4,267		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	0		305	448		13.00
14.00	Total (see instructions)	0	3,035	873	4,715		14.00
15.00	CAH visits	0	0	0	0		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)						27.00
28.00	Observation Bed Days	0		17	54		28.00
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				69		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)			0	34		32.00
33.00	LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-3 Part I Date/Time Prepared: 2/13/2013 6:17 pm

	Cost Center Description	Full Time Equivalents			Discharges		
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
		9.00	10.00	11.00	12.00	13.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	598	1.00
2.00	HMO					0	2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	249.00	0.00	0	598	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00	249.00	0.00			27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 2/13/2013 6:17 pm

	Cost Center Description	Discharges			
		Title XIX	Total All Patients		
		14.00	15.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	217	1,082		1.00
2.00	HMO				2.00
3.00	HMO IPF Subprovider				3.00
4.00	HMO IRF Subprovider				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF				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)	217	1,082		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF				16.00
17.00	SUBPROVIDER - IRF				17.00
18.00	SUBPROVIDER				18.00
19.00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE				21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00	HOSPICE				24.00
25.00	CMHC - CMHC				25.00
26.00	RURAL HEALTH CLINIC				26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days - IRF				31.00
32.00	Labor & delivery days (see instructions)				32.00
33.00	LTCH non-covered days				33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-10 | Date/Time Prepared: 2/13/2013 6:17 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)	0.438445	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,423,873	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,918,351	5.00
6.00	Medicaid charges	12,498,457	6.00
7.00	Medicaid cost (line 1 times line 6)	5,479,886	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,137,662	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	25,234	9.00
10.00	Stand-alone SCHIP charges	120,146	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	52,677	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	27,443	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,165,105	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	4,419,045	1,003,823	5,422,868	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,937,508	440,121	2,377,629	21.00
22.00	Partial payment by patients approved for charity care	1,084,925	0	1,084,925	22.00
23.00	Cost of charity care (line 21 minus line 22)	852,583	440,121	1,292,704	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)	782,308	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	831,095	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	-48,787	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	-21,390	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,271,314	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,436,419	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A | Date/Time Prepared: 2/13/2013 6:17 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		3,050,958	3,050,958	2,362,341	5,413,299	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,373,590	1,373,590	111,770	1,485,360	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	115,044	4,038,841	4,153,885	0	4,153,885	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,592,837	4,406,401	5,999,238	-184,283	5,814,955	5.00
7.00	00700	OPERATION OF PLANT	435,100	690,352	1,125,452	0	1,125,452	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	156,125	156,125	8.00
9.00	00901	HOUSEKEEPING	369,479	180,973	550,452	-156,125	394,327	9.00
10.00	01000	DIETARY	455,479	321,505	776,984	-496,214	280,770	10.00
11.00	01100	CAFETERIA	0	0	0	494,398	494,398	11.00
13.00	01300	NURSING ADMINISTRATION	433,358	21,957	455,315	-8,655	446,660	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	230,306	247,332	477,638	-195,787	281,851	14.00
15.00	01500	PHARMACY	392,979	959,080	1,352,059	-929,269	422,790	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	419,966	95,484	515,450	0	515,450	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	33,365	33,365	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,437,755	329,547	1,767,302	592,545	2,359,847	30.00
43.00	04300	NURSERY	0	0	0	110,323	110,323	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	815,784	709,950	1,525,734	-250,620	1,275,114	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	752,557	68,789	821,346	-702,868	118,478	52.00
53.00	05300	ANESTHESIOLOGY	707,606	158,298	865,904	-10,505	855,399	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,070,075	736,415	1,806,490	-43,119	1,763,371	54.00
60.00	06000	LABORATORY	798,384	1,133,631	1,932,015	0	1,932,015	60.00
65.00	06500	RESPIRATORY THERAPY	311,783	120,834	432,617	0	432,617	65.00
66.00	06600	PHYSICAL THERAPY	1,166,259	83,161	1,249,420	0	1,249,420	66.00
68.00	06800	SPEECH PATHOLOGY	70,865	0	70,865	0	70,865	68.00
69.00	06900	ELECTROCARDIOLOGY	49,411	62,886	112,297	0	112,297	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	140,878	140,878	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	305,701	305,701	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	993,194	993,194	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	103,948	15,188	119,136	0	119,136	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,231,955	1,986,521	3,218,476	-33,367	3,185,109	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		2,289,828	2,289,828	-2,289,828	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,960,930	23,081,521	36,042,451	0	36,042,451	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CARE-A-VAN	2,027	815	2,842	0	2,842	194.00
200.00		TOTAL (SUM OF LINES 118-199)	12,962,957	23,082,336	36,045,293	0	36,045,293	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A | Date/Time Prepared: 2/13/2013 6:17 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	-159,001	5,254,298		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-282,553	1,202,807		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS	-507,032	3,646,853		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-747,888	5,067,067		5.00
7.00	00700	OPERATION OF PLANT	0	1,125,452		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	156,125		8.00
9.00	00901	HOUSEKEEPING	0	394,327		9.00
10.00	01000	DIETARY	0	280,770		10.00
11.00	01100	CAFETERIA	-90,957	403,441		11.00
13.00	01300	NURSING ADMINISTRATION	0	446,660		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	281,851		14.00
15.00	01500	PHARMACY	-21,508	401,282		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,870	513,580		16.00
17.00	01700	SOCIAL SERVICE	0	33,365		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,359,847		30.00
43.00	04300	NURSERY	0	110,323		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	451	1,275,565		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	118,478		52.00
53.00	05300	ANESTHESIOLOGY	-724,810	130,589		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,763,371		54.00
60.00	06000	LABORATORY	-25,570	1,906,445		60.00
65.00	06500	RESPIRATORY THERAPY	-625	431,992		65.00
66.00	06600	PHYSICAL THERAPY	-38,979	1,210,441		66.00
68.00	06800	SPEECH PATHOLOGY	0	70,865		68.00
69.00	06900	ELECTROCARDIOLOGY	0	112,297		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	140,878		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	305,701		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	993,194		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	119,136		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,524,758	1,660,351		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,125,100	31,917,351		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	CARE-A-VAN	0	2,842		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-4,125,100	31,920,193		200.00

RECLASSIFICATIONS | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-6 | Date/Time Prepared: 2/13/2013 6:17 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS STERILE PROCESSING SALARIES				
1.00	OPERATING ROOM	50.00	53,946	0	1.00
	TOTALS		53,946	0	
	B - RECLASS LABOR AND DELIVERY EXPENSES				
1.00	NURSERY	43.00	101,083	9,240	1.00
2.00	ADULTS & PEDIATRICS	30.00	542,919	49,626	2.00
	TOTALS		644,002	58,866	
	C - RECLASS SOCIAL SERVICE FEES				
1.00	SOCIAL SERVICE	17.00	0	33,365	1.00
	TOTALS		0	33,365	
	D - RECLASS PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	50,213	1.00
	TOTALS		0	50,213	
	E - RECLASS DRUG EXPENSE				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	993,194	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	993,194	
	F - RECLASS LAUNDRY EXPENSE				
1.00	LAUNDRY & LINEN SERVICE	8.00	32,633	123,492	1.00
	TOTALS		32,633	123,492	
	G - MEDICAL SUPPLY AND IMPLANTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	140,878	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	305,701	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	446,579	
	H - RECLASS CAFETERIA EXPENSE				
1.00	CAFETERIA	11.00	290,502	203,896	1.00
	TOTALS		290,502	203,896	
	I - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,219,072	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	70,756	2.00
	TOTALS		0	2,289,828	
	J - RECLASS BOND AMORIZATION EXPENSE				
1.00	OTHER CAP REL COSTS	3.00	0	134,070	1.00
	TOTALS		0	134,070	
500.00	Grand Total: Increases		1,021,083	4,333,503	500.00

RECLASSIFICATIONS | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-6 | Date/Time Prepared: 2/13/2013 6:17 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS STERILE PROCESSING SALARIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	53,946	0	0		1.00
	TOTALS		53,946	0			
	B - RECLASS LABOR AND DELIVERY EXPENSES						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	644,002	58,866	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		644,002	58,866			
	C - RECLASS SOCIAL SERVICE FEES						
1.00	EMERGENCY	91.00	0	33,365	0		1.00
	TOTALS		0	33,365			
	D - RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	50,213	5		1.00
	TOTALS		0	50,213			
	E - RECLASS DRUG EXPENSE						
1.00	DIETARY	10.00	0	1,816	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	8,655	0		2.00
3.00	PHARMACY	15.00	0	929,097	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	10,505	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	43,119	0		5.00
6.00	EMERGENCY	91.00	0	2	0		6.00
	TOTALS		0	993,194			
	F - RECLASS LAUNDRY EXPENSE						
1.00	HOUSEKEEPING	9.00	32,633	123,492	0		1.00
	TOTALS		32,633	123,492			
	G - MEDICAL SUPPLY AND IMPLANTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	141,841	0		1.00
2.00	PHARMACY	15.00	0	172	0		2.00
3.00	OPERATING ROOM	50.00	0	304,566	0		3.00
	TOTALS		0	446,579			
	H - RECLASS CAFETERIA EXPENSE						
1.00	DIETARY	10.00	290,502	203,896	0		1.00
	TOTALS		290,502	203,896			
	I - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	2,289,828	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	2,289,828			
	J - RECLASS BOND AMORIZATION EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	134,070	14		1.00
	TOTALS		0	134,070			
500.00	Grand Total: Decreases		1,021,083	4,333,503			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-7 Parts I-III Date/Time Prepared: 2/13/2013 6:17 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	936,822	0	0	0	0	1.00
2.00	Land Improvements	5,784,294	0	0	0	0	2.00
3.00	Buildings and Fixtures	41,413,367	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	10,917,282	1,037,607	0	1,037,607	88,238	6.00
7.00	HIT designated Assets	1,912,947	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	60,964,712	1,037,607	0	1,037,607	88,238	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	60,964,712	1,037,607	0	1,037,607	88,238	10.00

		SUMMARY OF CAPITAL					
	Cost Center Description	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	3,050,958	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,373,590	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,424,548	0	0	0	0	3.00

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	48,134,483	0	48,134,483	0.777440	39,038	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,779,599	0	13,779,599	0.222560	11,175	2.00
3.00	Total (sum of lines 1-2)	61,914,082	0	61,914,082	1.000000	50,213	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 2/13/2013 6:17 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	936,822	0				1.00
2.00	Land Improvements	5,784,294	0				2.00
3.00	Buildings and Fixtures	41,413,367	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	11,866,651	0				6.00
7.00	HIT designated Assets	1,912,947	0				7.00
8.00	Subtotal (sum of lines 1-7)	61,914,081	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	61,914,081	0				10.00

	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	3,050,958				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,373,590				2.00
3.00	Total (sum of lines 1-2)	0	4,424,548				3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	104,231	143,269	3,058,426	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	29,839	41,014	1,096,345	0	2.00
3.00	Total (sum of lines 1-2)	0	134,070	184,283	4,154,771	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 2/13/2013 6:17 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	2,052,603	39,038	0	104,231	5,254,298	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	65,448	11,175	0	29,839	1,202,807	2.00
3.00	Total (sum of lines 1-2)	2,118,051	50,213	0	134,070	6,457,105	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8 | Date/Time Prepared: 2/13/2013 6:17 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 #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-166,469	CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-5,308	CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)	B	-1,571	ADMINISTRATIVE & GENERAL	5.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00	Television and radio service (chapter 21)		0		0.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,547,295			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-242,962			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-90,957	CAFETERIA	11.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts	B	-1,870	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-419,438	CAP REL COSTS-MVBLE EQUIP	2.00	32.00
33.00	PHARMACY REBATES	B	-21,508	PHARMACY	15.00	33.00
33.01	ADMINISTRATIVE REBATES	B	-39,101	ADMINISTRATIVE & GENERAL	5.00	33.01
33.03	LABORATORY MISCELLANEOUS REVENUE	B	-2,582	LABORATORY	60.00	33.03
33.04	RESPIRATORY MISCELLANEOUS REVENUE	B	-625	RESPIRATORY THERAPY	65.00	33.04
33.05	PHYSICAL THERAPY MISCELLANEOUS REVEN	B	-38,979	PHYSICAL THERAPY	66.00	33.05
33.06	MISCELLANEOUS REVENUE	B	-175,349	ADMINISTRATIVE & GENERAL	5.00	33.06
33.07	CORPORATE OVERHEAD	B	-14,400	ADMINISTRATIVE & GENERAL	5.00	33.07
33.08	LAPSING FY 92 ADDITION	A	819	CAP REL COSTS-MVBLE EQUIP	2.00	33.08
33.09	CRNA SALARIES	A	-707,606	ANESTHESIOLOGY	53.00	33.09
33.10	CRNA BENEFITS RECLASS	A	-76,799	EMPLOYEE BENEFITS	4.00	33.10
33.11	CRNA CONTRACT EXPENSE	A	-17,204	ANESTHESIOLOGY	53.00	33.11
33.12	MARKETING SALARY	A	-35,735	ADMINISTRATIVE & GENERAL	5.00	33.12
33.13	MARKETING BENEFITS EXPENSE	A	-9,938	EMPLOYEE BENEFITS	4.00	33.13
33.14	MARKETING OTHER EXPENSE	A	-5,523	ADMINISTRATIVE & GENERAL	5.00	33.14
33.15	ADVERTISING EXPENSE	A	-54,921	ADMINISTRATIVE & GENERAL	5.00	33.15
33.16	LOBBYING EXPENSE	A	-14,162	ADMINISTRATIVE & GENERAL	5.00	33.16
33.17	PROVIDER TAX	A	-439,816	ADMINISTRATIVE & GENERAL	5.00	33.17
33.18	PROVIDER TAX ASSISTANCE PAYMENT	A	-13,032	ADMINISTRATIVE & GENERAL	5.00	33.18
33.19	FUNDED DEPRECIATION TRUSTEE FEES	A	17,231	ADMINISTRATIVE & GENERAL	5.00	33.19
33.20			0		0.00	33.20
33.21			0		0.00	33.21

ADJUSTMENTS TO EXPENSES | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8 | Date/Time Prepared: 2/13/2013 6:17 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	
		1.00	2.00	3.00	4.00	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,125,100			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8 | Date/Time Prepared: 2/13/2013 6:17 pm

	Cost Center Description	Wkst. A-7 Ref. 5.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	11		1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	11		2.00
3.00	Investment income - other (chapter 2)	0		3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0		4.00
5.00	Refunds and rebates of expenses (chapter 8)	0		5.00
6.00	Rental of provider space by suppliers (chapter 8)	0		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0		7.00
8.00	Television and radio service (chapter 21)	0		8.00
9.00	Parking lot (chapter 21)	0		9.00
10.00	Provider-based physician adjustment	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0		11.00
12.00	Related organization transactions (chapter 10)	0		12.00
13.00	Laundry and linen service	0		13.00
14.00	Cafeteria-employees and guests	0		14.00
15.00	Rental of quarters to employee and others	0		15.00
16.00	Sale of medical and surgical supplies to other than patients	0		16.00
17.00	Sale of drugs to other than patients	0		17.00
18.00	Sale of medical records and abstracts	0		18.00
19.00	Nursing school (tuition, fees, books, etc.)	0		19.00
20.00	Vending machines	0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	0		26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	0		27.00
28.00	Non-physician Anesthetist			28.00
29.00	Physicians' assistant	0		29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	9		32.00
33.00	PHARMACY REBATES	0		33.00
33.01	ADMINISTRATIVE REBATES	0		33.01
33.03	LABORATORY MISCELLANEOUS REVENUE	0		33.03
33.04	RESPIRATORY MISCELLANEOUS REVENUE	0		33.04
33.05	PHYSICAL THERAPY MISCELLANEOUS REVEN	0		33.05
33.06	MISCELLANEOUS REVENUE	0		33.06
33.07	CORPORATE OVERHEAD	0		33.07
33.08	LAPSING FY 92 ADDITION	9		33.08
33.09	CRNA SALARIES	0		33.09
33.10	CRNA BENEFITS RECLASS	0		33.10
33.11	CRNA CONTRACT EXPENSE	0		33.11
33.12	MARKETING SALARY	0		33.12
33.13	MARKETING BENEFITS EXPENSE	0		33.13
33.14	MARKETING OTHER EXPENSE	0		33.14
33.15	ADVERTISING EXPENSE	0		33.15
33.16	LOBBYING EXPENSE	0		33.16
33.17	PROVIDER TAX	0		33.17
33.18	PROVIDER TAX ASSISTANCE PAYMENT	0		33.18
33.19	FUNDED DEPRECIATION TRUSTEE FEES	0		33.19
33.20		0		33.20
33.21		0		33.21
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8-1 | Date/Time Prepared: 2/13/2013 6:17 pm

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00		1.00	CAP REL COSTS-BLDG & FIXT	HO BUILDING CAPITAL	1.00
2.00		2.00	CAP REL COSTS-MVBLE EQUIP	MO MME CAPITAL	2.00
3.00		5.00	ADMINISTRATIVE & GENERAL	HO INTEREST OPERATING	3.00
4.00		5.00	ADMINISTRATIVE & GENERAL	HO MANAGEMENT OPERATING	4.00
4.01		4.00	EMPLOYEE BENEFITS	SELF INSRUANCE BENEFITS	4.01
4.02		14.00	CENTRAL SERVICES & SUPPLY	INVENTORY ITEMS	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

		Symbol (1)	Name	Percentage of Ownership		
		1.00	2.00	3.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00		B		0.00		6.00
7.00		B		0.00		7.00
8.00		B		0.00		8.00
9.00		B		0.00		9.00
10.00				0.00		10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8-1 | Date/Time Prepared: 2/13/2013 6:17 pm

		Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
		4.00	5.00	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		7,468	0	7,468	9		1.00
2.00		141,374	0	141,374	9		2.00
3.00		20,945	0	20,945	0		3.00
4.00		2,302,015	2,294,469	7,546	0		4.00
4.01		1,414,180	1,834,475	-420,295	0		4.01
4.02		71,085	71,085	0	0		4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	3,957,067	4,200,029	-242,962			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

		Related Organization(s) and/or Home Office			
		Name	Percentage of Ownership	Type of Business	
		4.00	5.00	6.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				
6.00		MEMORIAL HL SYS	100.00	MANAGEMENT/HO	6.00
7.00		MEMORIAL MD CTR	0.00	HOSPITAL	7.00
8.00		TAYLORVILLE MC	0.00	HOSPITAL	8.00
9.00		MEMORIAL HOME S	0.00	HOME HEALTH	9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:				100.00

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 2/13/2013 6:17 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		5.00	ADMINISTRATIVE & GENERAL	1,808	0	1.00
2.00		13.00	NURSING ADMINISTRATION	2,485	0	2.00
3.00		50.00	OPERATING ROOM	1,804	0	3.00
4.00		53.00	ANESTHESIOLOGY	85,792	0	4.00
5.00		60.00	LABORATORY	22,988	22,988	5.00
6.00		76.97	CARDIAC REHABILITATION	6,353	0	6.00
7.00		91.00	EMERGENCY	1,723,924	1,524,758	7.00
8.00		91.00	DR. A	26,250	0	8.00
9.00		50.00	DR. B	-451	-451	9.00
10.00		0.00		0	0	10.00
200.00				1,870,953	1,547,295	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 2/13/2013 6:17 pm

		Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
		5.00	6.00	7.00	8.00	9.00	
1.00		1,808	0	0	0	0	1.00
2.00		2,485	0	0	0	0	2.00
3.00		1,804	0	0	0	0	3.00
4.00		85,792	0	0	0	0	4.00
5.00		0	0	0	0	0	5.00
6.00		6,353	0	0	0	0	6.00
7.00		199,166	0	0	0	0	7.00
8.00		26,250	0	0	0	0	8.00
9.00		0	0	0	0	0	9.00
10.00		0	0	0	0	0	10.00
200.00		323,658		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 2/13/2013 6:17 pm

		Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	
		12.00	13.00	14.00	15.00	16.00	
1.00		0	0	0	0	0	1.00
2.00		0	0	0	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00		0	0	0	0	0	5.00
6.00		0	0	0	0	0	6.00
7.00		0	0	0	0	0	7.00
8.00		0	0	0	0	0	8.00
9.00		0	0	0	0	0	9.00
10.00		0	0	0	0	0	10.00
200.00		0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 2/13/2013 6:17 pm

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	0		1.00
2.00		0	0		2.00
3.00		0	0		3.00
4.00		0	0		4.00
5.00		0	22,988		5.00
6.00		0	0		6.00
7.00		0	1,524,758		7.00
8.00		0	0		8.00
9.00		0	-451		9.00
10.00		0	0		10.00
200.00		0	1,547,295		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part I Date/Time Prepared: 2/13/2013 6:17 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,254,298	5,254,298				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,202,807		1,202,807			2.00
4.00	00400	EMPLOYEE BENEFITS	3,646,853	5,192	0	3,652,045		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,067,067	370,952	296,880	469,790	6,204,689	5.00
7.00	00700	OPERATION OF PLANT	1,125,452	1,645,590	52,002	131,273	2,954,317	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	156,125	25,425	0	9,846	191,396	8.00
9.00	00901	HOUSEKEEPING	394,327	142,213	46	101,629	638,215	9.00
10.00	01000	DIETARY	280,770	122,423	16,878	49,775	469,846	10.00
11.00	01100	CAFETERIA	403,441	67,845	29,720	87,647	588,653	11.00
13.00	01300	NURSING ADMINISTRATION	446,660	9,185	0	130,748	586,593	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	281,851	104,852	906	53,209	440,818	14.00
15.00	01500	PHARMACY	401,282	57,640	4,881	118,565	582,368	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	513,580	80,536	0	126,707	720,823	16.00
17.00	01700	SOCIAL SERVICE	33,365	0	0	0	33,365	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,359,847	813,876	53,171	597,582	3,824,476	30.00
43.00	04300	NURSERY	110,323	16,506	5,294	30,498	162,621	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,275,565	459,919	127,517	262,404	2,125,405	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	118,478	26,756	5,685	32,752	183,671	52.00
53.00	05300	ANESTHESIOLOGY	130,589	13,489	32,794	0	176,872	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,763,371	333,058	459,122	322,850	2,878,401	54.00
60.00	06000	LABORATORY	1,906,445	200,075	37,021	240,879	2,384,420	60.00
65.00	06500	RESPIRATORY THERAPY	431,992	40,113	13,920	94,067	580,092	65.00
66.00	06600	PHYSICAL THERAPY	1,210,441	225,056	16,594	351,870	1,803,961	66.00
68.00	06800	SPEECH PATHOLOGY	70,865	4,792	0	21,381	97,038	68.00
69.00	06900	ELECTROCARDIOLOGY	112,297	7,943	22,858	14,908	158,006	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	140,878	0	0	0	140,878	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	305,701	0	0	0	305,701	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	993,194	0	0	0	993,194	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	119,136	173,717	0	31,362	324,215	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,660,351	266,101	27,518	371,691	2,325,661	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,917,351	5,213,254	1,202,807	3,651,433	31,875,695	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	41,044	0	0	41,044	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CARE-A-VAN	2,842	0	0	612	3,454	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	31,920,193	5,254,298	1,202,807	3,652,045	31,920,193	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part I Date/Time Prepared: 2/13/2013 6:17 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,204,689					5.00
7.00	00700	OPERATION OF PLANT	712,824	3,667,141				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,180	28,843	266,419			8.00
9.00	00901	HOUSEKEEPING	153,990	161,332	0	953,537		9.00
10.00	01000	DIETARY	113,365	138,881	384	38,087	760,563	10.00
11.00	01100	CAFETERIA	142,031	76,966	740	21,107	0	11.00
13.00	01300	NURSING ADMINISTRATION	141,534	10,420	0	2,858	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	106,361	118,948	568	32,621	0	14.00
15.00	01500	PHARMACY	140,515	65,388	0	17,932	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	173,922	91,363	0	25,056	0	16.00
17.00	01700	SOCIAL SERVICE	8,050	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	922,779	923,291	74,667	253,207	739,419	30.00
43.00	04300	NURSERY	39,238	18,726	2,470	5,135	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	512,822	521,749	35,293	143,086	21,144	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,317	30,354	2,653	8,324	0	52.00
53.00	05300	ANESTHESIOLOGY	42,676	15,303	0	4,197	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	694,506	377,834	36,795	103,619	0	54.00
60.00	06000	LABORATORY	575,318	226,972	9	62,246	0	60.00
65.00	06500	RESPIRATORY THERAPY	139,966	45,505	0	12,480	0	65.00
66.00	06600	PHYSICAL THERAPY	435,263	255,312	28,453	70,018	0	66.00
68.00	06800	SPEECH PATHOLOGY	23,414	5,436	0	1,491	0	68.00
69.00	06900	ELECTROCARDIOLOGY	38,124	9,010	6,102	2,471	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,991	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	73,760	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	239,640	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	78,227	197,072	0	54,046	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	561,140	301,874	68,633	82,787	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,193,953	3,620,579	256,767	940,768	760,563	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,903	46,562	0	12,769	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	9,652	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CARE-A-VAN	833	0	0	0	0	194.00
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)	6,204,689	3,667,141	266,419	953,537	760,563	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part I | Date/Time Prepared: 2/13/2013 6:17 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00901	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	829,497					11.00
13.00	01300	NURSING ADMINISTRATION	29,277	770,682				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25,400	0	724,716			14.00
15.00	01500	PHARMACY	21,776	0	1,074	829,053		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	58,046	0	26	0	1,069,236	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	183,959	376,457	57,920	0	257,816	30.00
43.00	04300	NURSERY	7,392	15,481	711	0	15,954	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	75,837	154,029	92,691	0	106,254	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,935	16,622	764	0	10,849	52.00
53.00	05300	ANESTHESIOLOGY	14,493	0	10,157	8,862	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	82,214	0	35,602	36,376	96,362	54.00
60.00	06000	LABORATORY	88,012	0	263,404	0	56,477	60.00
65.00	06500	RESPIRATORY THERAPY	27,067	0	3,407	0	17,230	65.00
66.00	06600	PHYSICAL THERAPY	91,562	0	16,718	0	43,395	66.00
68.00	06800	SPEECH PATHOLOGY	4,602	0	0	0	3,191	68.00
69.00	06900	ELECTROCARDIOLOGY	4,710	0	412	0	7,020	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	59,275	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	128,626	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	783,813	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	7,754	0	505	0	11,806	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	98,700	208,093	53,424	2	431,395	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	828,736	770,682	724,716	829,053	1,057,749	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	11,487	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CARE-A-VAN	761	0	0	0	0	194.00
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)	829,497	770,682	724,716	829,053	1,069,236	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part I | Date/Time Prepared: 2/13/2013 6:17 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00901	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	41,415					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	7,613,991	0	7,613,991		30.00
43.00	04300	NURSERY	0	267,728	0	267,728		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,788,310	0	3,788,310		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	305,489	0	305,489		52.00
53.00	05300	ANESTHESIOLOGY	0	272,560	0	272,560		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,341,709	0	4,341,709		54.00
60.00	06000	LABORATORY	0	3,656,858	0	3,656,858		60.00
65.00	06500	RESPIRATORY THERAPY	0	825,747	0	825,747		65.00
66.00	06600	PHYSICAL THERAPY	0	2,744,682	0	2,744,682		66.00
68.00	06800	SPEECH PATHOLOGY	0	135,172	0	135,172		68.00
69.00	06900	ELECTROCARDIOLOGY	0	225,855	0	225,855		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	234,144	0	234,144		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	508,087	0	508,087		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,016,647	0	2,016,647		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	673,625	0	673,625		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	41,415	4,173,124	0	4,173,124		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,415	31,783,728	0	31,783,728		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	110,278	0	110,278		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	21,139	0	21,139		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	CARE-A-VAN	0	5,048	0	5,048		194.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	41,415	31,920,193	0	31,920,193		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part II | Date/Time Prepared: 2/13/2013 6:17 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	5,192	0	5,192	5,192	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,721	370,952	296,880	684,553	668	5.00
7.00	00700	OPERATION OF PLANT	12,564	1,645,590	52,002	1,710,156	187	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	25,425	0	25,425	14	8.00
9.00	00901	HOUSEKEEPING	0	142,213	46	142,259	145	9.00
10.00	01000	DIETARY	0	122,423	16,878	139,301	71	10.00
11.00	01100	CAFETERIA	0	67,845	29,720	97,565	125	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,185	0	9,185	186	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	104,852	906	105,758	76	14.00
15.00	01500	PHARMACY	0	57,640	4,881	62,521	169	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	80,536	0	80,536	180	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,567	813,876	53,171	888,614	846	30.00
43.00	04300	NURSERY	37	16,506	5,294	21,837	43	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,845	459,919	127,517	607,281	373	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	39	26,756	5,685	32,480	47	52.00
53.00	05300	ANESTHESIOLOGY	3,096	13,489	32,794	49,379	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	156,684	333,058	459,122	948,864	459	54.00
60.00	06000	LABORATORY	78	200,075	37,021	237,174	343	60.00
65.00	06500	RESPIRATORY THERAPY	392	40,113	13,920	54,425	134	65.00
66.00	06600	PHYSICAL THERAPY	6,036	225,056	16,594	247,686	500	66.00
68.00	06800	SPEECH PATHOLOGY	0	4,792	0	4,792	30	68.00
69.00	06900	ELECTROCARDIOLOGY	6,895	7,943	22,858	37,696	21	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	173,717	0	173,717	45	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	83	266,101	27,518	293,702	529	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	244,037	5,213,254	1,202,807	6,660,098	5,191	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	41,044	0	41,044	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CARE-A-VAN	0	0	0	0	1	194.00
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)	244,037	5,254,298	1,202,807	6,701,142	5,192	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part II | Date/Time Prepared: 2/13/2013 6:17 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	685,221					5.00
7.00	00700	OPERATION OF PLANT	78,721	1,789,064				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,100	14,072	44,611			8.00
9.00	00901	HOUSEKEEPING	17,006	78,708	0	238,118		9.00
10.00	01000	DIETARY	12,520	67,755	64	9,511	229,222	10.00
11.00	01100	CAFETERIA	15,685	37,549	124	5,271	0	11.00
13.00	01300	NURSING ADMINISTRATION	15,630	5,083	0	714	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,746	58,030	95	8,146	0	14.00
15.00	01500	PHARMACY	15,518	31,901	0	4,478	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,207	44,572	0	6,257	0	16.00
17.00	01700	SOCIAL SERVICE	889	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	101,911	450,442	12,504	63,231	222,850	30.00
43.00	04300	NURSERY	4,333	9,136	414	1,282	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	56,634	254,542	5,910	35,732	6,372	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,894	14,808	444	2,079	0	52.00
53.00	05300	ANESTHESIOLOGY	4,713	7,466	0	1,048	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	76,698	184,331	6,161	25,876	0	54.00
60.00	06000	LABORATORY	63,535	110,731	1	15,544	0	60.00
65.00	06500	RESPIRATORY THERAPY	15,457	22,200	0	3,116	0	65.00
66.00	06600	PHYSICAL THERAPY	48,068	124,557	4,764	17,485	0	66.00
68.00	06800	SPEECH PATHOLOGY	2,586	2,652	0	372	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,210	4,396	1,022	617	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,754	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,146	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,465	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	8,639	96,144	0	13,496	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	61,970	147,273	11,492	20,674	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	684,035	1,766,348	42,995	234,929	229,222	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,094	22,716	0	3,189	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,616	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CARE-A-VAN	92	0	0	0	0	194.00
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)	685,221	1,789,064	44,611	238,118	229,222	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part II | Date/Time Prepared: 2/13/2013 6:17 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00901	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	156,319					11.00
13.00	01300	NURSING ADMINISTRATION	5,517	36,315				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,787	0	188,638			14.00
15.00	01500	PHARMACY	4,104	0	280	118,971		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,939	0	7	0	161,698	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,667	17,740	15,076	0	38,989	30.00
43.00	04300	NURSERY	1,393	729	185	0	2,413	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,292	7,258	24,127	0	16,068	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,495	783	199	0	1,641	52.00
53.00	05300	ANESTHESIOLOGY	2,731	0	2,644	1,272	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,493	0	9,267	5,220	14,573	54.00
60.00	06000	LABORATORY	16,586	0	68,560	0	8,541	60.00
65.00	06500	RESPIRATORY THERAPY	5,101	0	887	0	2,606	65.00
66.00	06600	PHYSICAL THERAPY	17,255	0	4,352	0	6,562	66.00
68.00	06800	SPEECH PATHOLOGY	867	0	0	0	483	68.00
69.00	06900	ELECTROCARDIOLOGY	888	0	107	0	1,062	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	15,429	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	33,480	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	112,479	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,461	0	132	0	1,785	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	18,600	9,805	13,906	0	65,238	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	156,176	36,315	188,638	118,971	159,961	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,737	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CARE-A-VAN	143	0	0	0	0	194.00
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)	156,319	36,315	188,638	118,971	161,698	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part II | Date/Time Prepared: 2/13/2013 6:17 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00901	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	889					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,846,870	0	1,846,870		30.00
43.00	04300	NURSERY	0	41,765	0	41,765		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,028,589	0	1,028,589		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	58,870	0	58,870		52.00
53.00	05300	ANESTHESIOLOGY	0	69,253	0	69,253		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,286,942	0	1,286,942		54.00
60.00	06000	LABORATORY	0	521,015	0	521,015		60.00
65.00	06500	RESPIRATORY THERAPY	0	103,926	0	103,926		65.00
66.00	06600	PHYSICAL THERAPY	0	471,229	0	471,229		66.00
68.00	06800	SPEECH PATHOLOGY	0	11,782	0	11,782		68.00
69.00	06900	ELECTROCARDIOLOGY	0	50,019	0	50,019		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19,183	0	19,183		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	41,626	0	41,626		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	138,944	0	138,944		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	295,419	0	295,419		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	889	644,078	0	644,078		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	889	6,629,510	0	6,629,510		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	68,043	0	68,043		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,353	0	3,353		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	CARE-A-VAN	0	236	0	236		194.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	889	6,701,142	0	6,701,142		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B-1 | Date/Time Prepared: 2/13/2013 6:17 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	118,414					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,581,230				2.00
4.00	00400	EMPLOYEE BENEFITS	117	0	12,104,572			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,360	390,283	1,557,102	-6,204,689	25,715,504	5.00
7.00	00700	OPERATION OF PLANT	37,086	68,363	435,100	0	2,954,317	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	573	0	32,633	0	191,396	8.00
9.00	00901	HOUSEKEEPING	3,205	60	336,846	0	638,215	9.00
10.00	01000	DIETARY	2,759	22,188	164,977	0	469,846	10.00
11.00	01100	CAFETERIA	1,529	39,071	290,502	0	588,653	11.00
13.00	01300	NURSING ADMINISTRATION	207	0	433,358	0	586,593	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,363	1,191	176,360	0	440,818	14.00
15.00	01500	PHARMACY	1,299	6,417	392,979	0	582,368	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,815	0	419,966	0	720,823	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	33,365	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,342	69,900	1,980,674	0	3,824,476	30.00
43.00	04300	NURSERY	372	6,959	101,083	0	162,621	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,365	167,636	869,730	0	2,125,405	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	603	7,474	108,555	0	183,671	52.00
53.00	05300	ANESTHESIOLOGY	304	43,112	0	0	176,872	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,506	603,567	1,070,075	0	2,878,401	54.00
60.00	06000	LABORATORY	4,509	48,669	798,384	0	2,384,420	60.00
65.00	06500	RESPIRATORY THERAPY	904	18,300	311,783	0	580,092	65.00
66.00	06600	PHYSICAL THERAPY	5,072	21,815	1,166,259	0	1,803,961	66.00
68.00	06800	SPEECH PATHOLOGY	108	0	70,865	0	97,038	68.00
69.00	06900	ELECTROCARDIOLOGY	179	30,049	49,411	0	158,006	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	140,878	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	305,701	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	993,194	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,915	0	103,948	0	324,215	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,997	36,176	1,231,955	0	2,325,661	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	117,489	1,581,230	12,102,545	-6,204,689	25,671,006	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	925	0	0	0	41,044	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CARE-A-VAN	0	0	2,027	0	3,454	194.00
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)	5,254,298	1,202,807	3,652,045		6,204,689	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	44.372270	0.760678	0.301708		0.241282	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,192		685,221	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000429		0.026646	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B-1 | Date/Time Prepared: 2/13/2013 6:17 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	72,851					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	573	182,589				8.00
9.00	00901	HOUSEKEEPING	3,205	0	69,073			9.00
10.00	01000	DIETARY	2,759	263	2,759	18,705		10.00
11.00	01100	CAFETERIA	1,529	507	1,529	0	22,893	11.00
13.00	01300	NURSING ADMINISTRATION	207	0	207	0	808	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,363	389	2,363	0	701	14.00
15.00	01500	PHARMACY	1,299	0	1,299	0	601	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,815	0	1,815	0	1,602	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,342	51,174	18,342	18,185	5,077	30.00
43.00	04300	NURSERY	372	1,693	372	0	204	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,365	24,188	10,365	520	2,093	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	603	1,818	603	0	219	52.00
53.00	05300	ANESTHESIOLOGY	304	0	304	0	400	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,506	25,217	7,506	0	2,269	54.00
60.00	06000	LABORATORY	4,509	6	4,509	0	2,429	60.00
65.00	06500	RESPIRATORY THERAPY	904	0	904	0	747	65.00
66.00	06600	PHYSICAL THERAPY	5,072	19,500	5,072	0	2,527	66.00
68.00	06800	SPEECH PATHOLOGY	108	0	108	0	127	68.00
69.00	06900	ELECTROCARDIOLOGY	179	4,182	179	0	130	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,915	0	3,915	0	214	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,997	47,037	5,997	0	2,724	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	71,926	175,974	68,148	18,705	22,872	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	925	0	925	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,615	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CARE-A-VAN	0	0	0	0	21	194.00
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)	3,667,141	266,419	953,537	760,563	829,497	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	50.337552	1.459119	13.804772	40.660946	36.233652	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,789,064	44,611	238,118	229,222	156,319	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	24.557851	0.244325	3.447338	12.254584	6.828244	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B-1 | Date/Time Prepared: 2/13/2013 6:17 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00901	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	159,401					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,722,413				14.00
15.00	01500	PHARMACY	0	2,553	982,723			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	61	0	3,351		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	315	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	77,863	137,658	0	808	0	30.00
43.00	04300	NURSERY	3,202	1,690	0	50	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,858	220,297	0	333	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,438	1,815	0	34	0	52.00
53.00	05300	ANESTHESIOLOGY	0	24,140	10,505	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	84,614	43,119	302	0	54.00
60.00	06000	LABORATORY	0	626,023	0	177	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,098	0	54	0	65.00
66.00	06600	PHYSICAL THERAPY	0	39,734	0	136	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	10	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	979	0	22	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	140,878	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	305,701	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	929,097	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,201	0	37	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	43,040	126,971	2	1,352	315	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	159,401	1,722,413	982,723	3,315	315	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	36	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CARE-A-VAN	0	0	0	0	0	194.00
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)	770,682	724,716	829,053	1,069,236	41,415	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.834863	0.420756	0.843628	319.079678	131.476190	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	36,315	188,638	118,971	161,698	889	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.227822	0.109520	0.121063	48.253656	2.822222	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet C Part I Date/Time Prepared: 2/13/2013 6:17 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	7,613,991		7,613,991	0	0	30.00
43.00	04300	NURSERY	267,728		267,728	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,788,310		3,788,310	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	305,489		305,489	0	0	52.00
53.00	05300	ANESTHESIOLOGY	272,560		272,560	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,341,709		4,341,709	0	0	54.00
60.00	06000	LABORATORY	3,656,858		3,656,858	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	825,747	0	825,747	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,744,682	0	2,744,682	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	135,172	0	135,172	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	225,855		225,855	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	234,144		234,144	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	508,087		508,087	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,016,647		2,016,647	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	673,625		673,625	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,173,124		4,173,124	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	95,773		95,773		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	31,879,501	0	31,879,501	0	0	200.00
201.00		Less Observation Beds	95,773		95,773		0	201.00
202.00		Total (see instructions)	31,783,728	0	31,783,728	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet C Part I Date/Time Prepared: 2/13/2013 6:17 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,231,783		4,231,783			30.00
43.00	04300	NURSERY	302,676		302,676			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,209,799	4,412,524	5,622,323	0.673798	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	748,977	838,862	1,587,839	0.192393	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	335,270	733,841	1,069,111	0.254941	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,165,110	20,805,565	21,970,675	0.197614	0.000000	54.00
60.00	06000	LABORATORY	1,755,136	9,571,641	11,326,777	0.322851	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	554,172	1,129,915	1,684,087	0.490323	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	455,451	4,143,945	4,599,396	0.596748	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	54,555	210,313	264,868	0.510337	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	250,535	922,318	1,172,853	0.192569	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	840,587	707,337	1,547,924	0.151263	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,063,312	277,895	1,341,207	0.378828	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,367,872	4,971,594	7,339,466	0.274768	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	379,170	379,170	1.776578	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	99,933	7,882,694	7,982,627	0.522776	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,308	63,874	69,182	1.384363	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	15,440,476	57,051,488	72,491,964			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,440,476	57,051,488	72,491,964			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet C Part I Date/Time Prepared: 2/13/2013 6:17 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
		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: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part II Date/Time Prepared: 2/13/2013 6:17 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	1,028,589	5,622,323	0.182947	314,166	57,476	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	58,870	1,587,839	0.037076	0	0	52.00
53.00	05300	ANESTHESIOLOGY	69,253	1,069,111	0.064776	89,290	5,784	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,286,942	21,970,675	0.058575	800,403	46,884	54.00
60.00	06000	LABORATORY	521,015	11,326,777	0.045999	1,026,115	47,200	60.00
65.00	06500	RESPIRATORY THERAPY	103,926	1,684,087	0.061711	372,348	22,978	65.00
66.00	06600	PHYSICAL THERAPY	471,229	4,599,396	0.102455	236,466	24,227	66.00
68.00	06800	SPEECH PATHOLOGY	11,782	264,868	0.044483	41,199	1,833	68.00
69.00	06900	ELECTROCARDIOLOGY	50,019	1,172,853	0.042647	197,938	8,441	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,183	1,547,924	0.012393	457,100	5,665	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	41,626	1,341,207	0.031036	479,547	14,883	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	138,944	7,339,466	0.018931	1,165,525	22,065	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	295,419	379,170	0.779120	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	644,078	7,982,627	0.080685	214	17	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	69,182	0.000000	544	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50-199)	4,740,875	67,957,505		5,180,855	257,453	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part IV | Date/Time Prepared: 2/13/2013 6:17 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part IV Date/Time Prepared: 2/13/2013 6:17 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	5,622,323	0.000000	0.000000	314,166	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,587,839	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,069,111	0.000000	0.000000	89,290	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,970,675	0.000000	0.000000	800,403	54.00
60.00	06000	LABORATORY	0	11,326,777	0.000000	0.000000	1,026,115	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,684,087	0.000000	0.000000	372,348	65.00
66.00	06600	PHYSICAL THERAPY	0	4,599,396	0.000000	0.000000	236,466	66.00
68.00	06800	SPEECH PATHOLOGY	0	264,868	0.000000	0.000000	41,199	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,172,853	0.000000	0.000000	197,938	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,547,924	0.000000	0.000000	457,100	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,341,207	0.000000	0.000000	479,547	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,339,466	0.000000	0.000000	1,165,525	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	379,170	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	7,982,627	0.000000	0.000000	214	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	69,182	0.000000	0.000000	544	92.00
		OTHER REIMBURSABLE COST CENTERS						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00		Total (lines 50-199)	0	67,957,505			5,180,855	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part IV | Date/Time Prepared: 2/13/2013 6:17 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part V Date/Time Prepared: 2/13/2013 6:17 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.)		
			1.00	2.00	3.00	4.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.673798	0	1,644,525	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.192393	0	387	0		52.00
53.00	05300	ANESTHESIOLOGY	0.254941	0	193,917	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197614	0	8,355,208	0		54.00
60.00	06000	LABORATORY	0.322851	0	4,106,490	0		60.00
65.00	06500	RESPIRATORY THERAPY	0.490323	0	374,771	0		65.00
66.00	06600	PHYSICAL THERAPY	0.596748	0	1,717,245	0		66.00
68.00	06800	SPEECH PATHOLOGY	0.510337	0	23,564	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0.192569	0	467,334	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.151263	0	274,942	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.378828	0	167,242	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.274768	0	2,773,651	2,313		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	1.776578	0	247,161	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.522776	0	2,587,356	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.384363	0	22,116	0		92.00
		OTHER REIMBURSABLE COST CENTERS						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0		98.00
200.00		Subtotal (see instructions)		0	22,955,909	2,313		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	22,955,909	2,313		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part V Date/Time Prepared: 2/13/2013 6:17 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs PPS Services (see inst.)	Costs Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,108,078	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	74	0		52.00
53.00	05300	ANESTHESIOLOGY	0	49,437	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,651,106	0		54.00
60.00	06000	LABORATORY	0	1,325,784	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	183,759	0		65.00
66.00	06600	PHYSICAL THERAPY	0	1,024,763	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	12,026	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	89,994	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,589	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	63,356	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	762,111	636		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	439,101	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	1,352,608	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	30,617	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00		Subtotal (see instructions)	0	8,134,403	636		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	8,134,403	636		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141322 | Component CCN: 14Z322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part V | Date/Time Prepared: 2/13/2013 6:17 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			1.00	2.00	3.00	4.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.673798	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.192393	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0.254941	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197614	0	0	0		54.00
60.00	06000	LABORATORY	0.322851	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0.490323	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0.596748	0	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0.510337	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0.192569	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.151263	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.378828	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.274768	0	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	1.776578	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.522776	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.384363	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0		98.00
200.00		Subtotal (see instructions)		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		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141322 | Component CCN: 14Z322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part V | Date/Time Prepared: 2/13/2013 6:17 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: PPS Services (see inst.)	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00		Subtotal (see instructions)	0	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	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-1 | Date/Time Prepared: 2/13/2013 6:17 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,321	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,516	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)	3,462	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	194	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)	581	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)	30	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,260	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)	194	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)	581	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	118.65	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	118.65	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,613,991	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)	3,560	25.00
26.00	Total swing-bed cost (see instructions)	1,378,085	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,235,906	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	3,756,436	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	3,756,436	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.660059	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)	1,085.05	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)	6,235,906	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)	1,773.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,008,291	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)	4,008,291	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-1 | Date/Time Prepared: 2/13/2013 6:17 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,678,647	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,686,938	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)	344,075	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,030,450	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,374,525	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)	54	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,773.58	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	95,773	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-1 | Date/Time Prepared: 2/13/2013 6:17 pm

Title XVIII | Hospital | Cost

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-3 | Date/Time Prepared: 2/13/2013 6:17 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,404,362		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.673798	314,166	211,684	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.192393	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.254941	89,290	22,764	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197614	800,403	158,171	54.00
60.00	06000	LABORATORY	0.322851	1,026,115	331,282	60.00
65.00	06500	RESPIRATORY THERAPY	0.490323	372,348	182,571	65.00
66.00	06600	PHYSICAL THERAPY	0.596748	236,466	141,111	66.00
68.00	06800	SPEECH PATHOLOGY	0.510337	41,199	21,025	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192569	197,938	38,117	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.151263	457,100	69,142	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.378828	479,547	181,666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.274768	1,165,525	320,249	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.776578	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.522776	214	112	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.384363	544	753	92.00
		OTHER REIMBURSABLE COST CENTERS				
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		5,180,855	1,678,647	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		5,180,855		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-3

Component CCN: 14Z322 | Date/Time Prepared: 2/13/2013 6:17 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		386,580		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.673798	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.192393	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.254941	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197614	103,004	20,355	54.00
60.00	06000	LABORATORY	0.322851	184,836	59,674	60.00
65.00	06500	RESPIRATORY THERAPY	0.490323	96,888	47,506	65.00
66.00	06600	PHYSICAL THERAPY	0.596748	164,886	98,395	66.00
68.00	06800	SPEECH PATHOLOGY	0.510337	5,874	2,998	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192569	9,508	1,831	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.151263	105,859	16,013	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.378828	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.274768	368,694	101,305	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.776578	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.522776	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.384363	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		1,039,549	348,077	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,039,549		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141322	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/13/2013 6:17 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,135,039	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)	8,135,039	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)	8,216,389	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)	50,401	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,792,183	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	4,373,805	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	4,373,805	30.00
31.00	Primary payer payments	54	31.00
32.00	Subtotal (line 30 minus line 31)	4,373,751	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)	754,181	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	754,181	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	596,098	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	5,127,932	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	5,127,932	40.00
41.00	Interim payments	5,845,925	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	-717,993	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	111,460	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 2/13/2013 6:17 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,518,794		5,863,865	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	05/11/2012	149,261		0	3.01
3.02		09/12/2012	68,499		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	05/11/2012	17,940	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)		217,760		-17,940	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,736,554		5,845,925	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		432,713		717,993	6.02
7.00	Total Medicare program liability (see instructions)		5,303,841		5,127,932	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 2/13/2013 6:17 pm

Component CCN: 14Z322 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,645,761		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	05/11/2012	115,699		0	3.01
3.02		09/12/2012	42,048		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)		157,747		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,803,508		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		84,356		0	6.02
7.00	Total Medicare program liability (see instructions)		1,719,152		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141322	Period: From 10/01/2011 To 09/30/2012	Worksheet E-1 Part II Date/Time Prepared: 2/13/2013 6:17 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	1,082	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	2,260	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	70	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	3,462	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	72,491,964	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	5,422,868	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	905,925	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	840,194	8.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)	840,194	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141322 | Component CCN: 14Z322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet E-2 | Date/Time Prepared: 2/13/2013 6:17 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,388,270	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	351,558	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	775	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,739,828	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,739,828	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,739,828	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	20,676	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,719,152	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	1,719,152	0	19.00
20.00	Interim payments	1,803,508	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	-84,356	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	24,690	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141322	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part V Date/Time Prepared: 2/13/2013 6:17 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	5,686,938	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	5,686,938	4.00
5.00	Primary payer payments	3,969	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,739,838	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	5,739,838	19.00
20.00	Deductibles (exclude professional component)	509,732	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	5,230,106	22.00
23.00	Coinsurance	3,179	23.00
24.00	Subtotal (line 22 minus line 23)	5,226,927	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	76,914	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	76,914	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	59,828	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,303,841	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	5,303,841	30.00
31.00	Interim payments	5,736,554	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)	-432,713	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	81,360	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet G | Date/Time Prepared: 2/13/2013 6:17 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	11,870,920	0	0	0	1.00
2.00	Temporary investments	2,809,564	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,446,774	0	0	0	4.00
5.00	Other receivable	348,267	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,401,166	0	0	0	6.00
7.00	Inventory	461,762	0	0	0	7.00
8.00	Prepaid expenses	180,546	0	0	0	8.00
9.00	Other current assets	1,142,400	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)	23,859,067	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	936,822	0	0	0	12.00
13.00	Land improvements	5,784,294	0	0	0	13.00
14.00	Accumulated depreciation	-815,860	0	0	0	14.00
15.00	Buildings	41,487,559	0	0	0	15.00
16.00	Accumulated depreciation	-4,491,711	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	11,866,652	0	0	0	23.00
24.00	Accumulated depreciation	-6,712,834	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	1,912,947	0	0	0	27.00
28.00	Accumulated depreciation	-419,438	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)	49,548,431	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	9,478,209	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	951,858	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,430,067	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	83,837,565	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	767,322	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,068,087	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	201,110	0	0	0	40.00
41.00	Deferred income	1,142,400	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	3,319,488	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,498,407	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	42,380,310	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	42,380,310	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	48,878,717	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	34,958,848				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)	34,958,848	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	83,837,565	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet G-1 | Date/Time Prepared: 2/13/2013 6:17 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		31,346,020		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,607,807				2.00
3.00	Total (sum of line 1 and line 2)		34,953,827		0		3.00
4.00	BIOTERRORISM GRANT FUND	5,021		0			4.00
5.00		0		0			5.00
6.00		0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		5,021		0		10.00
11.00	Subtotal (line 3 plus line 10)		34,958,848		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0			12.00
13.00		0		0			13.00
14.00		0		0			14.00
15.00		0		0			15.00
16.00		0		0			16.00
17.00		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)		34,958,848		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet G-1 | Date/Time Prepared: 2/13/2013 6:17 pm

		Endowment Fund		Plant Fund			
		5.00	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	BIOTERRORISM GRANT FUND	0		0			4.00
5.00		0		0			5.00
6.00		0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		0		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0			12.00
13.00		0		0			13.00
14.00		0		0			14.00
15.00		0		0			15.00
16.00		0		0			16.00
17.00		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)		0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/13/2013 6:17 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,687,254		3,687,254	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	386,580		386,580	5.00
6.00	Swing bed - NF	15,741		15,741	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,089,575		4,089,575	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,089,575		4,089,575	17.00
18.00	Ancillary services	11,041,978	50,446,629	61,488,607	18.00
19.00	Outpatient services	109,471	8,025,762	8,135,233	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	NURSERY	314,916	0	314,916	27.00
27.01	PROFESSIONAL FEES	570,300	6,645,015	7,215,315	27.01
27.02	CARE A VAN	0	11,118	11,118	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	16,126,240	65,128,524	81,254,764	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		36,045,293		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	REBATES	60,609			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)		60,609		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		35,984,684		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141322 | Period: From 10/01/2011 To 09/30/2012 | Worksheet G-3 | Date/Time Prepared: 2/13/2013 6:17 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	81,254,764	1.00
2.00	Less contractual allowances and discounts on patients' accounts	46,089,517	2.00
3.00	Net patient revenues (line 1 minus line 2)	35,165,247	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	35,984,684	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-819,437	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	506,277	6.00
7.00	Income from investments	261,451	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	90,957	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	1,870	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	1,855,275	23.00
24.00	MISCELLANEOUS INCOME	386,097	24.00
24.01	MEANINGFUL USE INCOME	914,378	24.01
24.02	MANAGEMENT SUPPORT	14,400	24.02
24.03	GAIN ON SALE OF FIXED ASSETS	6,903	24.03
24.04	UNREALIZED GAINS ON INVESTMENTS	444,277	24.04
25.00	Total other income (sum of lines 6-24)	4,481,885	25.00
26.00	Total (line 5 plus line 25)	3,662,448	26.00
27.00	UNREALIZED LOSS ON INVESTMENTS	37,410	27.00
27.01	FUNDED DEPRECIATION TRUSTEE FEES	17,231	27.01
27.02		0	27.02
27.03		0	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	54,641	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,607,807	29.00