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: 141339	Period: From 10/01/2011 To 09/30/2012	Worksheet S Parts I-III Date/Time Prepared: 2/26/2013 2:56 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/26/2013 Time: 2:56 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by TAYLORVILLE MEMORIAL HOSPITAL (141339) 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	385,119	-715,783	0	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	56,842	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	441,961	-715,783	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2013 2:52 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 201 EAST PLEASANT STREET	PO Box:			1.00
2.00	City: TAYLORVILLE	State: IL	Zip Code: 62568	County: CHRISTIAN	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	TAYLORVILLE MEMORIAL HOSPITAL	141339	99914	1	09/01/2004	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	TAYLORVILLE MEMORIAL - SWB	14Z339	99914		09/01/2004	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	TAYLORVILLE SKILLED NURSING FACILITY	145539	99914		07/01/1966	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	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.	3	N	23.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2013 2:52 pm

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.			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: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2013 2:52 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: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2013 2:52 pm

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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	Y	N	109.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2013 2:52 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	159,141	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 SYSTEMS	Contractor's Name: MEMORIAL HEALTH SYSTEMS	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141339	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/26/2013 2:52 pm

							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						805,067	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: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2013 2:52 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	01/08/2013	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: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2013 2:52 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.				Y	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2013 2:52 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	01/08/2013		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: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2013 2:52 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	117,599.00		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	117,599.00		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						13.00
14.00	Total (see instructions)		25	9,150	117,599.00		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	44.00	20	7,320			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	99.00					25.00
26.00	RURAL HEALTH CLINIC	88.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		45				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: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2013 2:52 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	3,989	389	5,002		1.00
2.00	HMO		58	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	362	0	362		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	47		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	4,351	389	5,411		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	4,351	389	5,411		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	0	3,729	0	4,502		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	0	0	0	0		25.00
26.00	RURAL HEALTH CLINIC	0	0	0	0		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		55	177		28.00
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				19		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)			0	0		32.00
33.00	LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2013 2:52 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	1,019	1.00
2.00	HMO					16	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	249.35	0.00	0	1,019	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	0.00	17.89	0.00			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	0.00	0.00	0.00			25.00
26.00	RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00	267.24	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: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2013 2:52 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)	125	1,396		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)	125	1,396		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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-7 | Date/Time Prepared: 2/26/2013 2:52 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	09/01/2004	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	16	0	16	4.00
5.00		RVX	10	0	10	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	14	0	14	7.00
8.00		RHL	49	0	49	8.00
9.00		RMX	7	0	7	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	44	0	44	12.00
13.00		RUB	195	0	195	13.00
14.00		RUA	207	0	207	14.00
15.00		RVC	352	0	352	15.00
16.00		RVB	386	0	386	16.00
17.00		RVA	830	0	830	17.00
18.00		RHC	548	0	548	18.00
19.00		RHB	393	0	393	19.00
20.00		RHA	565	0	565	20.00
21.00		RMC	15	0	15	21.00
22.00		RMB	7	0	7	22.00
23.00		RMA	36	0	36	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	12	0	12	33.00
34.00		HC1	2	0	2	34.00
35.00		HB2	11	0	11	35.00
36.00		HB1	9	0	9	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	1	0	1	40.00
41.00		LC2	10	0	10	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	1	0	1	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	7	0	7	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	2	0	2	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-7 | Date/Time Prepared: 2/26/2013 2:52 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		3,729	0	3,729	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99914	99914	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	733,039	75.73	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	968,003			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-10 | Date/Time Prepared: 2/26/2013 2:52 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)	0.422742	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,415,075	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	10,542,622	6.00
7.00	Medicaid cost (line 1 times line 6)	4,456,809	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)	2,041,734	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,041,734	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	3,394,235	303,103	3,697,338	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,434,886	128,134	1,563,020	21.00
22.00	Partial payment by patients approved for charity care	1,344,092	0	1,344,092	22.00
23.00	Cost of charity care (line 21 minus line 22)	90,794	128,134	218,928	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,235,533	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	688,456	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	1,547,077	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	654,014	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	872,942	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,914,676	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A | Date/Time Prepared: 2/26/2013 2:52 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		1,329,056	1,329,056	968,019	2,297,075	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,592,434	1,592,434	104,177	1,696,611	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	83,390	3,618,615	3,702,005	0	3,702,005	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,841,780	4,103,111	5,944,891	-33,757	5,911,134	5.00
6.00	00600	MAINTENANCE & REPAIRS	604,360	60,371	664,731	0	664,731	6.00
7.00	00700	OPERATION OF PLANT	99,940	958,020	1,057,960	0	1,057,960	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	88,126	68,321	156,447	0	156,447	8.00
9.00	00900	HOUSEKEEPING	338,878	98,044	436,922	0	436,922	9.00
10.00	01000	DIETARY	434,440	460,064	894,504	-572,304	322,200	10.00
11.00	01100	CAFETERIA	0	0	0	572,304	572,304	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	403,764	43,429	447,193	0	447,193	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	41,902	214,908	256,810	-99,976	156,834	14.00
15.00	01500	PHARMACY	385,612	1,013,491	1,399,103	-974,892	424,211	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	448,479	67,103	515,582	0	515,582	16.00
17.00	01700	SOCIAL SERVICE	37,516	2,681	40,197	0	40,197	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,797,258	270,995	2,068,253	-2,080	2,066,173	30.00
44.00	04400	SKILLED NURSING FACILITY	733,039	448,212	1,181,251	-319,742	861,509	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	549,022	430,953	979,975	-190,395	789,580	50.00
53.00	05300	ANESTHESIOLOGY	422,935	344,800	767,735	-1,150	766,585	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	806,484	330,471	1,136,955	-60	1,136,895	54.00
56.00	05600	RADIOISOTOPE	77,508	118,591	196,099	-268	195,831	56.00
57.00	05700	CT SCAN	0	256,413	256,413	0	256,413	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	122,758	47,963	170,721	0	170,721	58.00
60.00	06000	LABORATORY	828,953	1,016,003	1,844,956	-164	1,844,792	60.00
65.00	06500	RESPIRATORY THERAPY	425,082	150,409	575,491	-53,403	522,088	65.00
66.00	06600	PHYSICAL THERAPY	686,161	82,459	768,620	-7	768,613	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	318,492	318,492	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	77,776	16,031	93,807	0	93,807	68.00
69.00	06900	ELECTROCARDIOLOGY	130,557	32,570	163,127	0	163,127	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,804	59,082	92,886	249,309	342,195	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	130,835	130,835	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	965,604	965,604	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,344,935	1,881,437	3,226,372	-21,385	3,204,987	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,039,157	1,039,157	-1,039,157	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,844,459	20,155,194	32,999,653	0	32,999,653	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	2,578	2,530	5,108	0	5,108	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	12,847,037	20,157,724	33,004,761	0	33,004,761	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A | Date/Time Prepared: 2/26/2013 2:52 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	6,850	2,303,925		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-101,602	1,595,009		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS	-703,666	2,998,339		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-407,458	5,503,676		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	664,731		6.00
7.00	00700	OPERATION OF PLANT	0	1,057,960		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	156,447		8.00
9.00	00900	HOUSEKEEPING	0	436,922		9.00
10.00	01000	DIETARY	0	322,200		10.00
11.00	01100	CAFETERIA	-168,372	403,932		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	447,193		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	156,834		14.00
15.00	01500	PHARMACY	0	424,211		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-14,434	501,148		16.00
17.00	01700	SOCIAL SERVICE	0	40,197		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-9,750	2,056,423		30.00
44.00	04400	SKILLED NURSING FACILITY	-8,195	853,314		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	789,580		50.00
53.00	05300	ANESTHESIOLOGY	-726,807	39,778		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-33,256	1,103,639		54.00
56.00	05600	RADIOISOTOPE	0	195,831		56.00
57.00	05700	CT SCAN	0	256,413		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	170,721		58.00
60.00	06000	LABORATORY	-29,167	1,815,625		60.00
65.00	06500	RESPIRATORY THERAPY	-3,800	518,288		65.00
66.00	06600	PHYSICAL THERAPY	0	768,613		66.00
66.01	06601	PHYSICAL THERAPY SNF	0	318,492		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	93,807		68.00
69.00	06900	ELECTROCARDIOLOGY	-268	162,859		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	342,195		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	130,835		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	965,604		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-1,468,975	1,736,012		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.00	09900	CMHC	0	0		99.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,668,900	29,330,753		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	5,108		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118-199)	-3,668,900	29,335,861		200.00

RECLASSIFICATIONS | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-6 | Date/Time Prepared: 2/26/2013 2:52 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS CAFETERIA EXPENSES					
1.00	CAFETERIA	11.00	277,955	294,349		1.00
	TOTALS		277,955	294,349		
	B - RECLASS BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	965,604		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
	TOTALS		0	965,604		
	D - RECLASS BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	249,309		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	130,835		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
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
	TOTALS		0	380,144		
	E - RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	33,039		1.00
	TOTALS		0	33,039		
	F - RECLASS SNF THERAPY EXPENSE					
1.00	PHYSICAL THERAPY SNF	66.01	0	318,492		1.00
	TOTALS		0	318,492		
	G - RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	949,446		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	89,711		2.00
	TOTALS		0	1,039,157		
500.00	Grand Total: Increases		277,955	3,030,785		500.00

RECLASSIFICATIONS | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-6 | Date/Time Prepared: 2/26/2013 2:52 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA EXPENSES						
1.00	DIETARY	10.00	277,955	294,349	0		1.00
	TOTALS		277,955	294,349			
	B - RECLASS BILLABLE DRUGS						
1.00	PHARMACY	15.00	0	963,570	0		1.00
2.00	OPERATING ROOM	50.00	0	928	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	837	0		3.00
4.00	LABORATORY	60.00	0	164	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	105	0		5.00
	TOTALS		0	965,604			
	D - RECLASS BILLABLE SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	718	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	99,976	0		2.00
3.00	PHARMACY	15.00	0	11,322	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	2,080	0		4.00
5.00	SKILLED NURSING FACILITY	44.00	0	1,250	0		5.00
6.00	OPERATING ROOM	50.00	0	189,467	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	313	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	60	0		8.00
9.00	RADIOISOTOPE	56.00	0	268	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	53,298	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	7	0		11.00
12.00	EMERGENCY	91.00	0	21,385	0		12.00
	TOTALS		0	380,144			
	E - RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	33,039	5		1.00
	TOTALS		0	33,039			
	F - RECLASS SNF THERAPY EXPENSE						
1.00	SKILLED NURSING FACILITY	44.00	0	318,492	0		1.00
	TOTALS		0	318,492			
	G - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,039,157	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	1,039,157			
500.00	Grand Total: Decreases		277,955	3,030,785			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 2/26/2013 2:52 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	737,345	0	0	0	0	1.00
2.00	Land Improvements	2,852,592	355,909	0	355,909	0	2.00
3.00	Buildings and Fixtures	22,969,570	655,762	0	655,762	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	18,680,312	684,121	0	684,121	0	6.00
7.00	HIT designated Assets	2,110,095	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	47,349,914	1,695,792	0	1,695,792	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	47,349,914	1,695,792	0	1,695,792	0	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	1,329,056	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,592,434	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,921,490	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	27,571,178	0	27,571,178	0.562153	18,573	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	21,474,528	0	21,474,528	0.437847	14,466	2.00
3.00	Total (sum of lines 1-2)	49,045,706	0	49,045,706	1.000000	33,039	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 2/26/2013 2:52 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	737,345	0				1.00
2.00	Land Improvements	3,208,501	0				2.00
3.00	Buildings and Fixtures	23,625,332	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	19,364,433	0				6.00
7.00	HIT designated Assets	2,110,095	0				7.00
8.00	Subtotal (sum of lines 1-7)	49,045,706	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	49,045,706	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	1,329,056				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,592,434				2.00
3.00	Total (sum of lines 1-2)	0	2,921,490				3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	18,573	1,335,906	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	14,466	1,490,832	0	2.00
3.00	Total (sum of lines 1-2)	0	0	33,039	2,826,738	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 2/26/2013 2:52 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	949,446	18,573	0	0	2,303,925	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	89,711	14,466	0	0	1,595,009	2.00
3.00	Total (sum of lines 1-2)	1,039,157	33,039	0	0	3,898,934	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8 | Date/Time Prepared: 2/26/2013 2:52 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)		0	CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)		0		0.00	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)	B	-2,252	ADMINISTRATIVE & GENERAL	5.00	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	-1,803,114			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-12,239	RADIOLOGY-DIAGNOSTIC	54.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-420,756			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-123,586	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	-14,434	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	OCCUPATIONAL THERAPY	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	-231,274	CAP REL COSTS-MVBLE EQUIP	2.00	32.00
33.00	PROVIDER TAX EXPENSE	A	-393,579	ADMINISTRATIVE & GENERAL	5.00	33.00
33.01	MUTUAL ASSISTANCE PROGRAM EXPENSE	A	-16,470	ADMINISTRATIVE & GENERAL	5.00	33.01
33.02	CASH MANAGEMENT FEE	A	31,253	ADMINISTRATIVE & GENERAL	5.00	33.02
33.03	CRNA CONTRACT EXPENSE	A	-22,404	ANESTHESIOLOGY	53.00	33.03
33.04	CRNA SALARY EXPENSE	A	-422,935	ANESTHESIOLOGY	53.00	33.04
33.05	CRNA FICA EXPENSE	A	-19,526	ANESTHESIOLOGY	53.00	33.05
33.06	CRNA BENEFIT EXPENSE	A	-101,378	EMPLOYEE BENEFITS	4.00	33.06
33.07	MARKETING SALARY EXPENSE	A	-13,356	ADMINISTRATIVE & GENERAL	5.00	33.07
33.08	MARKETING FICA EXPENSE	A	-974	ADMINISTRATIVE & GENERAL	5.00	33.08
33.09	MARKETING BENEFIT EXPENSE	A	-3,201	EMPLOYEE BENEFITS	4.00	33.09
33.10	ADVERTISING EXPENSE	A	-9,050	ADMINISTRATIVE & GENERAL	5.00	33.10
33.11	MARKETING OTHER EXPENSE	A	5,347	ADMINISTRATIVE & GENERAL	5.00	33.11
33.12	LOBBYING EXPENSE	A	-15,133	ADMINISTRATIVE & GENERAL	5.00	33.12
33.13	MISCELLEANEOUS INCOME	B	-29,099	ADMINISTRATIVE & GENERAL	5.00	33.13
33.14	MISCELLANEOUS REVENUE - GUEST MEALS	B	-44,786	CAFETERIA	11.00	33.14
33.15	IRS TAX PENALTY	A	-5,954	ADMINISTRATIVE & GENERAL	5.00	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,668,900			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8 | Date/Time Prepared: 2/26/2013 2:52 pm

	Cost Center Description	Wkst. A-7 Ref.					
		5.00					
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0					1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0					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)	9					7.00
8.00	Television and radio service (chapter 21)	9					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	PROVIDER TAX EXPENSE	0					33.00
33.01	MUTUAL ASSISTANCE PROGRAM EXPENSE	0					33.01
33.02	CASH MANAGEMENT FEE	0					33.02
33.03	CRNA CONTRACT EXPENSE	0					33.03
33.04	CRNA SALARY EXPENSE	0					33.04
33.05	CRNA FICA EXPENSE	0					33.05
33.06	CRNA BENEFIT EXPENSE	0					33.06
33.07	MARKETING SALARY EXPENSE	0					33.07
33.08	MARKETING FICA EXPENSE	0					33.08
33.09	MARKETING BENEFIT EXPENSE	0					33.09
33.10	ADVERTISING EXPENSE	0					33.10
33.11	MARKETING OTHER EXPENSE	0					33.11
33.12	LOBBYING EXPENSE	0					33.12
33.13	MISCELLEANEOUS INCOME	0					33.13
33.14	MISCELLANEOUS REVENUE - GUEST MEALS	0					33.14
33.15	IRS TAX PENALTY	0					33.15
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: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8-1 | Date/Time Prepared: 2/26/2013 2:52 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 BLDG CAPITAL	1.00
2.00		2.00	CAP REL COSTS-MVBLE EQUIP	HO 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	HEALTH INSURANCE	4.01
4.02		5.00	ADMINISTRATIVE & GENERAL	A&G PERSONNEL - ALMH	4.02
4.03		5.00	ADMINISTRATIVE & GENERAL	A&G PERSONNEL - MMC	4.03
4.04		5.00	ADMINISTRATIVE & GENERAL	A&G PERSONNEL - VNA	4.04
4.05		5.00	ADMINISTRATIVE & GENERAL	A&G ITEMS - MMC	4.05
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: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8-1 | Date/Time Prepared: 2/26/2013 2:52 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		6,850	0	6,850	9		1.00
2.00		129,672	0	129,672	9		2.00
3.00		19,211	0	19,211	0		3.00
4.00		2,137,230	2,102,104	35,126	0		4.00
4.01		1,794,786	2,393,873	-599,087	0		4.01
4.02		0	932	-932	0		4.02
4.03		0	4,003	-4,003	0		4.03
4.04		0	7,593	-7,593	0		4.04
4.05		344,055	344,055	0	0		4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	4,431,804	4,852,560	-420,756			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 HLTH	100.00	MANAGEMENT HO	6.00
7.00		MEMORIAL MD CTR	0.00	HOSPITAL	7.00
8.00		ABRAHAM LINCOLN	0.00	HOSPITAL	8.00
9.00		MEMORIAL VNA	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: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 2/26/2013 2:52 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		30.00	ADULTS & PEDIATRICS	9,750	9,750	1.00
2.00		44.00	SKILLED NURSING FACILITY	8,195	8,195	2.00
3.00		53.00	ANESTHESIOLOGY	261,942	261,942	3.00
4.00		54.00	RADIOLOGY-DIAGNOSTIC	21,017	21,017	4.00
5.00		60.00	LABORATORY	29,167	29,167	5.00
6.00		65.00	RESPIRATORY THERAPY	3,800	3,800	6.00
7.00		69.00	ELECTROCARDIOLOGY	268	268	7.00
8.00		91.00	EMERGENCY	1,687,415	1,468,975	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00				2,021,554	1,803,114	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 2/26/2013 2:52 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		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		218,440	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		218,440		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 2/26/2013 2:52 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: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 2/26/2013 2:52 pm

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	9,750		1.00
2.00		0	8,195		2.00
3.00		0	261,942		3.00
4.00		0	21,017		4.00
5.00		0	29,167		5.00
6.00		0	3,800		6.00
7.00		0	268		7.00
8.00		0	1,468,975		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		0	1,803,114		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/26/2013 2:52 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					18	1.00
2.00	Line 1 multiplied by 15 hours per week					270	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					92	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	145.75	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	66.29	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.15	33.15	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					9,662	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					9,662	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					9,662	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					66.29	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					17,898	22.00
23.00	Total salary equivalency (see instructions)					17,898	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					3,050	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					3,050	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					3,050	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					3,050	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/26/2013 2:52 pm

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	66.29	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	17,898	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	3,050	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	20,948	63.00
64.00	Total cost of outside supplier services (from your records)	9,255	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	3,050	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	3,050	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part I Date/Time Prepared: 2/26/2013 2:52 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	2,303,925	2,303,925				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,595,009		1,595,009			2.00
4.00	00400	EMPLOYEE BENEFITS	2,998,339	12,160	0	3,010,499		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,503,676	384,492	266,123	443,922	6,598,213	5.00
6.00	00600	MAINTENANCE & REPAIRS	664,731	104,247	98	147,742	916,818	6.00
7.00	00700	OPERATION OF PLANT	1,057,960	661,562	55,398	24,431	1,799,351	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	156,447	12,079	2,640	21,543	192,709	8.00
9.00	00900	HOUSEKEEPING	436,922	44,080	1,500	82,842	565,344	9.00
10.00	01000	DIETARY	322,200	84,285	6,944	38,254	451,683	10.00
11.00	01100	CAFETERIA	403,932	32,390	0	67,949	504,271	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	447,193	29,078	100	98,705	575,076	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	156,834	23,997	23,487	10,243	214,561	14.00
15.00	01500	PHARMACY	424,211	15,551	60,462	94,267	594,491	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	501,148	54,135	16,822	109,636	681,741	16.00
17.00	01700	SOCIAL SERVICE	40,197	4,008	0	9,171	53,376	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,056,423	195,933	33,729	439,359	2,725,444	30.00
44.00	04400	SKILLED NURSING FACILITY	853,314	107,867	20,467	179,199	1,160,847	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	789,580	135,806	129,094	134,214	1,188,694	50.00
53.00	05300	ANESTHESIOLOGY	39,778	12,253	49,947	0	101,978	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,103,639	88,911	313,005	197,154	1,702,709	54.00
56.00	05600	RADIOISOTOPE	195,831	0	2,062	18,948	216,841	56.00
57.00	05700	CT SCAN	256,413	0	0	0	256,413	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	170,721	0	439,102	30,010	639,833	58.00
60.00	06000	LABORATORY	1,815,625	44,455	28,192	202,647	2,090,919	60.00
65.00	06500	RESPIRATORY THERAPY	518,288	17,549	11,866	103,916	651,619	65.00
66.00	06600	PHYSICAL THERAPY	768,613	56,052	4,612	167,740	997,017	66.00
66.01	06601	PHYSICAL THERAPY SNF	318,492	0	0	0	318,492	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	93,807	4,196	0	19,013	117,016	68.00
69.00	06900	ELECTROCARDIOLOGY	162,859	14,264	14,972	31,916	224,011	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	342,195	0	0	8,264	350,459	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	130,835	0	0	0	130,835	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	965,604	0	0	0	965,604	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,736,012	129,156	112,779	328,784	2,306,731	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,330,753	2,268,506	1,593,401	3,009,869	29,293,096	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,687	0	0	8,687	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,108	26,732	1,608	630	34,078	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	29,335,861	2,303,925	1,595,009	3,010,499	29,335,861	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part I | Date/Time Prepared: 2/26/2013 2:52 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,598,213					5.00
6.00	00600	MAINTENANCE & REPAIRS	266,050	1,182,868				6.00
7.00	00700	OPERATION OF PLANT	522,152	710,839	3,032,342			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	55,922	26,988	32,088	307,707		8.00
9.00	00900	HOUSEKEEPING	164,057	2,752	117,100	8,770	858,023	9.00
10.00	01000	DIETARY	131,073	37,997	223,907	1,231	0	10.00
11.00	01100	CAFETERIA	146,334	0	86,044	2,185	5,901	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	166,881	1,243	77,247	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	62,263	19,886	63,750	1,016	5,901	14.00
15.00	01500	PHARMACY	172,515	4,705	41,313	0	5,901	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	197,834	3,995	143,810	0	11,802	16.00
17.00	01700	SOCIAL SERVICE	15,489	0	10,649	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	790,891	168,943	520,503	125,415	297,418	30.00
44.00	04400	SKILLED NURSING FACILITY	336,865	39,861	286,552	104,975	115,662	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	344,946	25,479	360,773	19,170	94,418	50.00
53.00	05300	ANESTHESIOLOGY	29,593	2,486	32,551	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	494,107	13,494	236,194	9,385	47,209	54.00
56.00	05600	RADIOISOTOPE	62,925	0	0	0	0	56.00
57.00	05700	CT SCAN	74,408	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	185,672	0	0	0	0	58.00
60.00	06000	LABORATORY	606,762	19,265	118,097	800	23,604	60.00
65.00	06500	RESPIRATORY THERAPY	189,093	8,434	46,619	585	5,901	65.00
66.00	06600	PHYSICAL THERAPY	289,323	18,377	148,903	9,169	47,209	66.00
66.01	06601	PHYSICAL THERAPY SNF	92,423	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	33,957	3,906	11,147	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	65,006	7,191	37,894	0	5,901	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	101,699	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,967	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	280,208	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	669,388	45,987	343,108	22,647	173,493	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,585,803	1,161,828	2,938,249	305,348	840,320	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,521	0	23,078	0	5,901	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,889	21,040	71,015	2,359	11,802	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	6,598,213	1,182,868	3,032,342	307,707	858,023	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part I Date/Time Prepared: 2/26/2013 2:52 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	845,891					10.00
11.00	01100	CAFETERIA	0	744,735				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	22,353	0	842,800		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,074	0	14,904	389,355	14.00
15.00	01500	PHARMACY	0	21,504	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	59,362	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,301	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	515,437	169,974	0	358,429	22,816	30.00
44.00	04400	SKILLED NURSING FACILITY	330,454	76,622	0	161,577	3,778	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	37,274	0	78,593	36,609	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	9,128	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	74,472	0	0	5,623	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	25,361	56.00
57.00	05700	CT SCAN	0	0	0	0	19,255	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	3,059	58.00
60.00	06000	LABORATORY	0	75,283	0	0	124,814	60.00
65.00	06500	RESPIRATORY THERAPY	0	33,708	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	48,271	0	0	1,405	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,263	0	0	110	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,299	0	16,372	1,286	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	83,195	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	43,660	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	396	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	100,805	0	212,560	8,742	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	845,891	744,565	0	842,435	389,237	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	170	0	365	118	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	845,891	744,735	0	842,800	389,355	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part I | Date/Time Prepared: 2/26/2013 2:52 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	840,429					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,098,544				16.00
17.00	01700	SOCIAL SERVICE	0	0	82,815			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	275,905	65,107	6,036,282	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	24,291	17,171	2,658,655	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	62,360	0	2,248,316	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	175,736	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,091	196,868	0	2,852,152	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	305,127	0	56.00
57.00	05700	CT SCAN	0	0	0	350,076	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	828,564	0	58.00
60.00	06000	LABORATORY	0	74,686	0	3,134,230	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,964	0	947,923	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,526	0	1,566,200	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	410,915	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,538	0	172,937	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	15,952	0	383,912	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	535,353	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	212,462	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	767,441	0	0	2,013,649	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	897	316,149	537	4,201,044	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	840,429	987,239	82,815	29,033,533	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	40,187	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	111,305	0	262,141	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	840,429	1,098,544	82,815	29,335,861	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part I | Date/Time Prepared: 2/26/2013 2:52 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	6,036,282		30.00
44.00	04400	SKILLED NURSING FACILITY	2,658,655		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,248,316		50.00
53.00	05300	ANESTHESIOLOGY	175,736		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,852,152		54.00
56.00	05600	RADIOISOTOPE	305,127		56.00
57.00	05700	CT SCAN	350,076		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	828,564		58.00
60.00	06000	LABORATORY	3,134,230		60.00
65.00	06500	RESPIRATORY THERAPY	947,923		65.00
66.00	06600	PHYSICAL THERAPY	1,566,200		66.00
66.01	06601	PHYSICAL THERAPY SNF	410,915		66.01
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	172,937		68.00
69.00	06900	ELECTROCARDIOLOGY	383,912		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	535,353		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	212,462		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,013,649		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0		88.00
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	4,201,044		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC	0		99.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,033,533		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	40,187		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	262,141		192.00
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	29,335,861		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part II | Date/Time Prepared: 2/26/2013 2:52 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	12,160	0	12,160	12,160	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	80,485	384,492	266,123	731,100	1,796	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	104,247	98	104,345	597	6.00
7.00	00700	OPERATION OF PLANT	0	661,562	55,398	716,960	99	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,079	2,640	14,719	87	8.00
9.00	00900	HOUSEKEEPING	0	44,080	1,500	45,580	334	9.00
10.00	01000	DIETARY	291	84,285	6,944	91,520	154	10.00
11.00	01100	CAFETERIA	0	32,390	0	32,390	274	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	29,078	100	29,178	399	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,559	23,997	23,487	49,043	41	14.00
15.00	01500	PHARMACY	0	15,551	60,462	76,013	381	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	54,135	16,822	70,957	443	16.00
17.00	01700	SOCIAL SERVICE	0	4,008	0	4,008	37	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,760	195,933	33,729	236,422	1,774	30.00
44.00	04400	SKILLED NURSING FACILITY	1,092	107,867	20,467	129,426	724	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	135,806	129,094	264,900	542	50.00
53.00	05300	ANESTHESIOLOGY	0	12,253	49,947	62,200	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,318	88,911	313,005	411,234	796	54.00
56.00	05600	RADIOISOTOPE	0	0	2,062	2,062	77	56.00
57.00	05700	CT SCAN	102,498	0	0	102,498	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	439,102	439,102	121	58.00
60.00	06000	LABORATORY	0	44,455	28,192	72,647	818	60.00
65.00	06500	RESPIRATORY THERAPY	720	17,549	11,866	30,135	420	65.00
66.00	06600	PHYSICAL THERAPY	0	56,052	4,612	60,664	677	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,196	0	4,196	77	68.00
69.00	06900	ELECTROCARDIOLOGY	0	14,264	14,972	29,236	129	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	33	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	129,156	112,779	241,935	1,327	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	202,723	2,268,506	1,593,401	4,064,630	12,157	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,687	0	8,687	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	26,732	1,608	28,340	3	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	202,723	2,303,925	1,595,009	4,101,657	12,160	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part II | Date/Time Prepared: 2/26/2013 2:52 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	732,896					5.00
6.00	00600	MAINTENANCE & REPAIRS	29,552	134,494				6.00
7.00	00700	OPERATION OF PLANT	57,998	80,825	855,882			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,212	3,069	9,057	33,144		8.00
9.00	00900	HOUSEKEEPING	18,223	313	33,052	945	98,447	9.00
10.00	01000	DIETARY	14,559	4,320	63,198	133	0	10.00
11.00	01100	CAFETERIA	16,254	0	24,286	235	677	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	18,536	141	21,803	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,916	2,261	17,993	109	677	14.00
15.00	01500	PHARMACY	19,162	535	11,661	0	677	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,975	454	40,591	0	1,354	16.00
17.00	01700	SOCIAL SERVICE	1,720	0	3,006	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	87,843	19,209	146,911	13,509	34,125	30.00
44.00	04400	SKILLED NURSING FACILITY	37,418	4,532	80,880	11,307	13,271	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	38,315	2,897	101,828	2,065	10,833	50.00
53.00	05300	ANESTHESIOLOGY	3,287	283	9,188	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,883	1,534	66,666	1,011	5,417	54.00
56.00	05600	RADIOISOTOPE	6,989	0	0	0	0	56.00
57.00	05700	CT SCAN	8,265	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	20,624	0	0	0	0	58.00
60.00	06000	LABORATORY	67,397	2,190	33,333	86	2,708	60.00
65.00	06500	RESPIRATORY THERAPY	21,004	959	13,158	63	677	65.00
66.00	06600	PHYSICAL THERAPY	32,137	2,089	42,028	988	5,417	66.00
66.01	06601	PHYSICAL THERAPY SNF	10,266	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,772	444	3,146	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,221	818	10,696	0	677	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,296	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,217	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,124	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	74,353	5,229	96,843	2,439	19,906	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	731,518	132,102	829,324	32,890	96,416	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	280	0	6,514	0	677	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,098	2,392	20,044	254	1,354	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	732,896	134,494	855,882	33,144	98,447	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part II | Date/Time Prepared: 2/26/2013 2:52 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	173,884					10.00
11.00	01100	CAFETERIA	0	74,116				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	2,225	0	72,282		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	704	0	1,278	79,022	14.00
15.00	01500	PHARMACY	0	2,140	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,908	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	329	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	105,955	16,916	0	30,741	4,631	30.00
44.00	04400	SKILLED NURSING FACILITY	67,929	7,625	0	13,858	767	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,709	0	6,740	7,430	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,853	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,411	0	0	1,141	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	5,147	56.00
57.00	05700	CT SCAN	0	0	0	0	3,908	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	621	58.00
60.00	06000	LABORATORY	0	7,492	0	0	25,332	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,355	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,804	0	0	285	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	424	0	0	22	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,025	0	1,404	261	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	16,885	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	8,861	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	80	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	10,032	0	18,230	1,774	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	173,884	74,099	0	72,251	78,998	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	17	0	31	24	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	173,884	74,116	0	72,282	79,022	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part II | Date/Time Prepared: 2/26/2013 2:52 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	110,569					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	141,682				16.00
17.00	01700	SOCIAL SERVICE	0	0	9,100			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	35,584	7,154	740,774	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	3,133	1,887	372,757	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	8,043	0	447,302	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	76,811	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,485	25,391	0	584,969	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	14,275	0	56.00
57.00	05700	CT SCAN	0	0	0	114,671	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	460,468	0	58.00
60.00	06000	LABORATORY	0	9,633	0	221,636	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,543	0	71,314	0	65.00
66.00	06600	PHYSICAL THERAPY	0	842	0	149,931	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	10,266	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	327	0	12,408	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,057	0	53,524	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	28,214	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	13,078	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100,966	0	0	132,170	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	118	40,774	59	513,019	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	110,569	127,327	9,100	4,017,587	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	16,158	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	14,355	0	67,912	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	110,569	141,682	9,100	4,101,657	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part II | Date/Time Prepared: 2/26/2013 2:52 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	740,774		30.00
44.00	04400	SKILLED NURSING FACILITY	372,757		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	447,302		50.00
53.00	05300	ANESTHESIOLOGY	76,811		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	584,969		54.00
56.00	05600	RADIOISOTOPE	14,275		56.00
57.00	05700	CT SCAN	114,671		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	460,468		58.00
60.00	06000	LABORATORY	221,636		60.00
65.00	06500	RESPIRATORY THERAPY	71,314		65.00
66.00	06600	PHYSICAL THERAPY	149,931		66.00
66.01	06601	PHYSICAL THERAPY SNF	10,266		66.01
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	12,408		68.00
69.00	06900	ELECTROCARDIOLOGY	53,524		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,214		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,078		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	132,170		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0		88.00
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	513,019		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC	0		99.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,017,587		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,158		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	67,912		192.00
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	4,101,657		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B-1 | Date/Time Prepared: 2/26/2013 2:52 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	171,854					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,567,865				2.00
4.00	00400	EMPLOYEE BENEFITS	907	0	12,314,828			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,680	261,594	1,815,896	-6,598,213	22,737,648	5.00
6.00	00600	MAINTENANCE & REPAIRS	7,776	96	604,360	0	916,818	6.00
7.00	00700	OPERATION OF PLANT	49,347	54,455	99,940	0	1,799,351	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	901	2,595	88,126	0	192,709	8.00
9.00	00900	HOUSEKEEPING	3,288	1,474	338,878	0	565,344	9.00
10.00	01000	DIETARY	6,287	6,826	156,485	0	451,683	10.00
11.00	01100	CAFETERIA	2,416	0	277,955	0	504,271	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,169	98	403,764	0	575,076	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,790	23,087	41,902	0	214,561	14.00
15.00	01500	PHARMACY	1,160	59,433	385,612	0	594,491	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,038	16,536	448,479	0	681,741	16.00
17.00	01700	SOCIAL SERVICE	299	0	37,516	0	53,376	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,615	33,155	1,797,258	0	2,725,444	30.00
44.00	04400	SKILLED NURSING FACILITY	8,046	20,119	733,039	0	1,160,847	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,130	126,897	549,022	0	1,188,694	50.00
53.00	05300	ANESTHESIOLOGY	914	49,097	0	0	101,978	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,632	307,678	806,484	0	1,702,709	54.00
56.00	05600	RADIOISOTOPE	0	2,027	77,508	0	216,841	56.00
57.00	05700	CT SCAN	0	0	0	0	256,413	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	431,630	122,758	0	639,833	58.00
60.00	06000	LABORATORY	3,316	27,712	828,953	0	2,090,919	60.00
65.00	06500	RESPIRATORY THERAPY	1,309	11,664	425,082	0	651,619	65.00
66.00	06600	PHYSICAL THERAPY	4,181	4,534	686,161	0	997,017	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	318,492	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	313	0	77,776	0	117,016	68.00
69.00	06900	ELECTROCARDIOLOGY	1,064	14,717	130,557	0	224,011	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	33,804	0	350,459	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	130,835	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	965,604	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	9,634	110,860	1,344,935	0	2,306,731	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	169,212	1,566,284	12,312,250	-6,598,213	22,694,883	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	648	0	0	0	8,687	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,994	1,581	2,578	0	34,078	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	2,303,925	1,595,009	3,010,499		6,598,213	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.406293	1.017313	0.244461		0.290189	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,160		732,896	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000987		0.032233	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B-1 | Date/Time Prepared: 2/26/2013 2:52 pm

		Cost Center Description	MAINTENANCE & REPAIRS (HOURS OF SERVICE)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	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						5.00
6.00	00600	MAINTENANCE & REPAIRS	13,324					6.00
7.00	00700	OPERATION OF PLANT	8,007	85,144				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	304	901	343,539			8.00
9.00	00900	HOUSEKEEPING	31	3,288	9,791	4,362		9.00
10.00	01000	DIETARY	428	6,287	1,374	0	34,168	10.00
11.00	01100	CAFETERIA	0	2,416	2,439	30	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	14	2,169	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	224	1,790	1,134	30	0	14.00
15.00	01500	PHARMACY	53	1,160	0	30	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	45	4,038	0	60	0	16.00
17.00	01700	SOCIAL SERVICE	0	299	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,903	14,615	140,021	1,512	20,820	30.00
44.00	04400	SKILLED NURSING FACILITY	449	8,046	117,199	588	13,348	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	287	10,130	21,402	480	0	50.00
53.00	05300	ANESTHESIOLOGY	28	914	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	152	6,632	10,478	240	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	217	3,316	893	120	0	60.00
65.00	06500	RESPIRATORY THERAPY	95	1,309	653	30	0	65.00
66.00	06600	PHYSICAL THERAPY	207	4,181	10,237	240	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	44	313	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	81	1,064	0	30	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	518	9,634	25,284	882	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,087	82,502	340,905	4,272	34,168	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	648	0	30	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	237	1,994	2,634	60	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	1,182,868	3,032,342	307,707	858,023	845,891	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	88.777244	35.614277	0.895697	196.704035	24.756819	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	134,494	855,882	33,144	98,447	173,884	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.094116	10.052170	0.096478	22.569234	5.089089	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B-1 | Date/Time Prepared: 2/26/2013 2:52 pm

		Cost Center Description	CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	39,481					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	1,185	0	194,075			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	375	0	3,432	1,166,767		14.00
15.00	01500	PHARMACY	1,140	0	0	0	3,522,778	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,147	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	175	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,011	0	82,537	68,372	0	30.00
44.00	04400	SKILLED NURSING FACILITY	4,062	0	37,207	11,321	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,976	0	18,098	109,704	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	27,353	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,948	0	0	16,850	302,181	54.00
56.00	05600	RADIOISOTOPE	0	0	0	75,999	0	56.00
57.00	05700	CT SCAN	0	0	0	57,702	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	9,167	0	58.00
60.00	06000	LABORATORY	3,991	0	0	374,025	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,787	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,559	0	0	4,210	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	226	0	0	330	0	68.00
69.00	06900	ELECTROCARDIOLOGY	546	0	3,770	3,853	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	249,309	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	130,835	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,188	3,216,838	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	5,344	0	48,947	26,196	3,759	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,472	0	193,991	1,166,414	3,522,778	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	9	0	84	353	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	744,735	0	842,800	389,355	840,429	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.863124	0.000000	4.342651	0.333704	0.238570	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	74,116	0	72,282	79,022	110,569	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.877257	0.000000	0.372444	0.067727	0.031387	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B-1 | Date/Time Prepared: 2/26/2013 2:52 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
			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
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
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	3,030			16.00
17.00	01700	SOCIAL SERVICE	0	463		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	761	364		30.00
44.00	04400	SKILLED NURSING FACILITY	67	96		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	172	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	543	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	206	0		60.00
65.00	06500	RESPIRATORY THERAPY	33	0		65.00
66.00	06600	PHYSICAL THERAPY	18	0		66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	7	0		68.00
69.00	06900	ELECTROCARDIOLOGY	44	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	872	3		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.00	09900	CMHC	0	0		99.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,723	463		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	307	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
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)	1,098,544	82,815		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	362.555776	178.866091		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	141,682	9,100		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	46.759736	19.654428		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet C Part I Date/Time Prepared: 2/26/2013 2:52 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	6,036,282		6,036,282	0	6,036,282	30.00
44.00	04400	SKILLED NURSING FACILITY	2,658,655		2,658,655	0	2,658,655	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,248,316		2,248,316	0	2,248,316	50.00
53.00	05300	ANESTHESIOLOGY	175,736		175,736	0	175,736	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,852,152		2,852,152	0	2,852,152	54.00
56.00	05600	RADIOISOTOPE	305,127		305,127	0	305,127	56.00
57.00	05700	CT SCAN	350,076		350,076	0	350,076	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	828,564		828,564	0	828,564	58.00
60.00	06000	LABORATORY	3,134,230		3,134,230	0	3,134,230	60.00
65.00	06500	RESPIRATORY THERAPY	947,923	0	947,923	0	947,923	65.00
66.00	06600	PHYSICAL THERAPY	1,566,200	0	1,566,200	0	1,566,200	66.00
66.01	06601	PHYSICAL THERAPY SNF	410,915	0	410,915	0	410,915	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	172,937	0	172,937	0	172,937	68.00
69.00	06900	ELECTROCARDIOLOGY	383,912		383,912	0	383,912	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	535,353		535,353	0	535,353	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	212,462		212,462	0	212,462	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,013,649		2,013,649	0	2,013,649	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	4,201,044		4,201,044	0	4,201,044	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	192,645		192,645		192,645	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0		0		0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	29,226,178	0	29,226,178	0	29,226,178	200.00
201.00		Less Observation Beds	192,645		192,645		192,645	201.00
202.00		Total (see instructions)	29,033,533	0	29,033,533	0	29,033,533	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet C Part I Date/Time Prepared: 2/26/2013 2:52 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	6,205,313		6,205,313			30.00
44.00	04400	SKILLED NURSING FACILITY	1,201,675		1,201,675			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	388,465	2,065,532	2,453,997	0.916185	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	45,793	193,564	239,357	0.734200	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	939,824	6,144,691	7,084,515	0.402590	0.000000	54.00
56.00	05600	RADIOISOTOPE	210,324	1,410,384	1,620,708	0.188268	0.000000	56.00
57.00	05700	CT SCAN	1,041,289	10,521,950	11,563,239	0.030275	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	511,913	5,516,692	6,028,605	0.137439	0.000000	58.00
60.00	06000	LABORATORY	2,077,041	7,790,712	9,867,753	0.317623	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	291,347	1,382,400	1,673,747	0.566348	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	301,812	2,341,813	2,643,625	0.592444	0.000000	66.00
66.01	06601	PHYSICAL THERAPY SNF	1,827,283	0	1,827,283	0.224878	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	82,219	338,942	421,161	0.410620	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	321,192	1,422,331	1,743,523	0.220193	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,520,892	1,812,486	4,333,378	0.123542	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72,729	258,626	331,355	0.641191	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,586,259	1,591,576	3,177,835	0.633654	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	141,092	5,946,033	6,087,125	0.690152	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,500	173,378	174,878	1.101597	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0			99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	19,767,962	48,911,110	68,679,072			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	19,767,962	48,911,110	68,679,072			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet C Part I Date/Time Prepared: 2/26/2013 2:52 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
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
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
66.01	06601	PHYSICAL THERAPY SNF	0.000000		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC			99.00
		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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet C Part I Date/Time Prepared: 2/26/2013 2:52 pm

Title XIX | Hospital

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,036,282		6,036,282	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	2,658,655		2,658,655	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,248,316		2,248,316	0	0	50.00
53.00	05300	ANESTHESIOLOGY	175,736		175,736	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,852,152		2,852,152	0	0	54.00
56.00	05600	RADIOISOTOPE	305,127		305,127	0	0	56.00
57.00	05700	CT SCAN	350,076		350,076	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	828,564		828,564	0	0	58.00
60.00	06000	LABORATORY	3,134,230		3,134,230	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	947,923	0	947,923	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,566,200	0	1,566,200	0	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	410,915	0	410,915	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	172,937	0	172,937	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	383,912		383,912	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	535,353		535,353	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	212,462		212,462	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,013,649		2,013,649	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	4,201,044		4,201,044	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	192,645		192,645		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0		0		0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	29,226,178	0	29,226,178	0	0	200.00
201.00		Less Observation Beds	192,645		192,645		0	201.00
202.00		Total (see instructions)	29,033,533	0	29,033,533	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet C Part I Date/Time Prepared: 2/26/2013 2:52 pm

Title XIX | Hospital

		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	6,205,313		6,205,313			30.00
44.00	04400	SKILLED NURSING FACILITY	1,201,675		1,201,675			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	388,465	2,065,532	2,453,997	0.916185	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	45,793	193,564	239,357	0.734200	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	939,824	6,144,691	7,084,515	0.402590	0.000000	54.00
56.00	05600	RADIOISOTOPE	210,324	1,410,384	1,620,708	0.188268	0.000000	56.00
57.00	05700	CT SCAN	1,041,289	10,521,950	11,563,239	0.030275	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	511,913	5,516,692	6,028,605	0.137439	0.000000	58.00
60.00	06000	LABORATORY	2,077,041	7,790,712	9,867,753	0.317623	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	291,347	1,382,400	1,673,747	0.566348	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	301,812	2,341,813	2,643,625	0.592444	0.000000	66.00
66.01	06601	PHYSICAL THERAPY SNF	1,827,283	0	1,827,283	0.224878	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	82,219	338,942	421,161	0.410620	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	321,192	1,422,331	1,743,523	0.220193	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,520,892	1,812,486	4,333,378	0.123542	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72,729	258,626	331,355	0.641191	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,586,259	1,591,576	3,177,835	0.633654	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	141,092	5,946,033	6,087,125	0.690152	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,500	173,378	174,878	1.101597	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0			99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	19,767,962	48,911,110	68,679,072			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	19,767,962	48,911,110	68,679,072			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet C Part I Date/Time Prepared: 2/26/2013 2:52 pm

Title XIX | Hospital

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
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
66.01	06601	PHYSICAL THERAPY SNF	0.000000		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC			99.00
		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: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part II Date/Time Prepared: 2/26/2013 2:52 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	447,302	2,453,997	0.182275	158,978	28,978	50.00
53.00	05300	ANESTHESIOLOGY	76,811	239,357	0.320906	26,327	8,448	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	584,969	7,084,515	0.082570	750,276	61,950	54.00
56.00	05600	RADIOISOTOPE	14,275	1,620,708	0.008808	124,210	1,094	56.00
57.00	05700	CT SCAN	114,671	11,563,239	0.009917	869,184	8,620	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	460,468	6,028,605	0.076381	381,729	29,157	58.00
60.00	06000	LABORATORY	221,636	9,867,753	0.022461	1,685,835	37,866	60.00
65.00	06500	RESPIRATORY THERAPY	71,314	1,673,747	0.042607	186,714	7,955	65.00
66.00	06600	PHYSICAL THERAPY	149,931	2,643,625	0.056714	243,071	13,786	66.00
66.01	06601	PHYSICAL THERAPY SNF	10,266	1,827,283	0.005618	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,408	421,161	0.029461	67,427	1,986	68.00
69.00	06900	ELECTROCARDIOLOGY	53,524	1,743,523	0.030699	261,683	8,033	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,214	4,333,378	0.006511	1,451,099	9,448	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,078	331,355	0.039468	72,694	2,869	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	132,170	3,177,835	0.041591	897,568	37,331	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	513,019	6,087,125	0.084279	1,391	117	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	174,878	0.000000	437	0	92.00
200.00		Total (lines 50-199)	2,904,056	61,272,084		7,178,623	257,638	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part IV | Date/Time Prepared: 2/26/2013 2:52 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
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
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part IV Date/Time Prepared: 2/26/2013 2:52 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	2,453,997	0.000000	0.000000	158,978	50.00
53.00	05300	ANESTHESIOLOGY	0	239,357	0.000000	0.000000	26,327	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,084,515	0.000000	0.000000	750,276	54.00
56.00	05600	RADIOISOTOPE	0	1,620,708	0.000000	0.000000	124,210	56.00
57.00	05700	CT SCAN	0	11,563,239	0.000000	0.000000	869,184	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	6,028,605	0.000000	0.000000	381,729	58.00
60.00	06000	LABORATORY	0	9,867,753	0.000000	0.000000	1,685,835	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,673,747	0.000000	0.000000	186,714	65.00
66.00	06600	PHYSICAL THERAPY	0	2,643,625	0.000000	0.000000	243,071	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	1,827,283	0.000000	0.000000	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	421,161	0.000000	0.000000	67,427	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,743,523	0.000000	0.000000	261,683	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,333,378	0.000000	0.000000	1,451,099	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	331,355	0.000000	0.000000	72,694	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,177,835	0.000000	0.000000	897,568	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	6,087,125	0.000000	0.000000	1,391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	174,878	0.000000	0.000000	437	92.00
200.00		Total (lines 50-199)	0	61,272,084			7,178,623	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part IV Date/Time Prepared: 2/26/2013 2:52 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
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
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
66.01	06601	PHYSICAL THERAPY SNF	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
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
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part V Date/Time Prepared: 2/26/2013 2:52 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	0.916185	0	1,032,456	0		50.00
53.00	05300	ANESTHESIOLOGY	0.734200	0	79,927	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.402590	0	1,922,700	0		54.00
56.00	05600	RADIOISOTOPE	0.188268	0	732,517	0		56.00
57.00	05700	CT SCAN	0.030275	0	4,743,004	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.137439	0	2,220,248	0		58.00
60.00	06000	LABORATORY	0.317623	0	3,337,341	0		60.00
65.00	06500	RESPIRATORY THERAPY	0.566348	0	552,319	0		65.00
66.00	06600	PHYSICAL THERAPY	0.592444	0	849,263	0		66.00
66.01	06601	PHYSICAL THERAPY SNF	0.224878	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0.410620	0	46,552	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0.220193	0	815,109	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.123542	0	785,897	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.641191	0	224,043	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.633654	0	938,115	4,043		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
90.00	09000	CLINIC	0.000000	0	0	0		90.00
91.00	09100	EMERGENCY	0.690152	0	1,963,298	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.101597	0	57,883	0		92.00
200.00		Subtotal (see instructions)		0	20,300,672	4,043		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	20,300,672	4,043		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part V Date/Time Prepared: 2/26/2013 2:52 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs PPS Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	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	945,921	0		50.00
53.00	05300	ANESTHESIOLOGY	0	58,682	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	774,060	0		54.00
56.00	05600	RADIOISOTOPE	0	137,910	0		56.00
57.00	05700	CT SCAN	0	143,594	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	305,149	0		58.00
60.00	06000	LABORATORY	0	1,060,016	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	312,805	0		65.00
66.00	06600	PHYSICAL THERAPY	0	503,141	0		66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	19,115	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	179,481	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	97,091	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	143,654	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	594,440	2,562		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	1,354,974	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	63,764	0		92.00
200.00		Subtotal (see instructions)	0	6,693,797	2,562		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	6,693,797	2,562		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141339 | Component CCN: 14Z339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part V | Date/Time Prepared: 2/26/2013 2:52 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	0.916185	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0.734200	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.402590	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0.188268	0	0	0		56.00
57.00	05700	CT SCAN	0.030275	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.137439	0	0	0		58.00
60.00	06000	LABORATORY	0.317623	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0.566348	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0.592444	0	0	0		66.00
66.01	06601	PHYSICAL THERAPY SNF	0.224878	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0.410620	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0.220193	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.123542	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.641191	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.633654	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
90.00	09000	CLINIC	0.000000	0	0	0		90.00
91.00	09100	EMERGENCY	0.690152	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.101597	0	0	0		92.00
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: 141339 | Component CCN: 14Z339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part V | Date/Time Prepared: 2/26/2013 2:52 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
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
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
66.01	06601	PHYSICAL THERAPY SNF	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
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
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141339 | Component CCN: 145539 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part IV | Date/Time Prepared: 2/26/2013 2:52 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
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
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141339 | Component CCN: 145539 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part IV Date/Time Prepared: 2/26/2013 2:52 pm

Title XVIII | Skilled Nursing Facility | PPS

		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	2,453,997	0.000000	0.000000	7,021	50.00
53.00	05300	ANESTHESIOLOGY	0	239,357	0.000000	0.000000	158	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,084,515	0.000000	0.000000	92,399	54.00
56.00	05600	RADIOISOTOPE	0	1,620,708	0.000000	0.000000	4,508	56.00
57.00	05700	CT SCAN	0	11,563,239	0.000000	0.000000	62,635	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	6,028,605	0.000000	0.000000	17,028	58.00
60.00	06000	LABORATORY	0	9,867,753	0.000000	0.000000	324,853	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,673,747	0.000000	0.000000	19,916	65.00
66.00	06600	PHYSICAL THERAPY	0	2,643,625	0.000000	0.000000	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	1,827,283	0.000000	0.000000	1,732,115	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	421,161	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,743,523	0.000000	0.000000	14,237	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,333,378	0.000000	0.000000	426,386	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	331,355	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,177,835	0.000000	0.000000	389,172	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	6,087,125	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	174,878	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	61,272,084			3,090,428	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141339 | Component CCN: 145539 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part IV Date/Time Prepared: 2/26/2013 2:52 pm

Title XVIII | Skilled Nursing Facility | PPS

		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
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
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
66.01	06601	PHYSICAL THERAPY SNF	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
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
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-1 | Date/Time Prepared: 2/26/2013 2:52 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)	5,588	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,179	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)	5,002	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	362	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)	47	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,989	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	362	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	117.79	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	117.79	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,036,282	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)	5,536	25.00
26.00	Total swing-bed cost (see instructions)	399,533	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,636,749	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	6,205,313	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	6,205,313	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.908375	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)	1,240.57	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)	5,636,749	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)	1,088.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,341,588	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)	4,341,588	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-1 | Date/Time Prepared: 2/26/2013 2:52 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	2,235,791	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,577,379	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	393,997	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	393,997	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)	177	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,088.39	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	192,645	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-1 | Date/Time Prepared: 2/26/2013 2:52 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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141339 Component CCN: 145539	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1 Date/Time Prepared: 2/26/2013 2:52 pm
	Title XVIII	Skilled Nursing Facility	PPS

	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)	4,502	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,502	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)	4,502	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,729	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,658,655	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,658,655	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	968,003	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	968,003	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	2.746536	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)	215.02	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)	2,658,655	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-1

Component CCN: 145539 | Date/Time Prepared: 2/26/2013 2:52 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,658,655	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	590.55	71.00
72.00	Program routine service cost (line 9 x line 71)	2,202,161	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	2,202,161	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	2,202,161	83.00
84.00	Program inpatient ancillary services (see instructions)	855,220	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	3,057,381	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-1

Component CCN: 145539 | Date/Time Prepared: 2/26/2013 2:52 pm

Title XVIII | Skilled Nursing Facility | PPS

	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: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-3 | Date/Time Prepared: 2/26/2013 2:52 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		4,543,296		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.916185	158,978	145,653	50.00
53.00	05300	ANESTHESIOLOGY	0.734200	26,327	19,329	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.402590	750,276	302,054	54.00
56.00	05600	RADIOISOTOPE	0.188268	124,210	23,385	56.00
57.00	05700	CT SCAN	0.030275	869,184	26,315	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.137439	381,729	52,464	58.00
60.00	06000	LABORATORY	0.317623	1,685,835	535,460	60.00
65.00	06500	RESPIRATORY THERAPY	0.566348	186,714	105,745	65.00
66.00	06600	PHYSICAL THERAPY	0.592444	243,071	144,006	66.00
66.01	06601	PHYSICAL THERAPY SNF	0.224878	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.410620	67,427	27,687	68.00
69.00	06900	ELECTROCARDIOLOGY	0.220193	261,683	57,621	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.123542	1,451,099	179,272	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.641191	72,694	46,611	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.633654	897,568	568,748	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.690152	1,391	960	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.101597	437	481	92.00
200.00		Total (sum of lines 50-94 and 96-98)		7,178,623	2,235,791	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)		7,178,623		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-3

Component CCN: 14Z339 | Date/Time Prepared: 2/26/2013 2:52 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		213,529		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.916185	24	22	50.00
53.00	05300	ANESTHESIOLOGY	0.734200	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.402590	16,173	6,511	54.00
56.00	05600	RADIOISOTOPE	0.188268	1,710	322	56.00
57.00	05700	CT SCAN	0.030275	7,662	232	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.137439	0	0	58.00
60.00	06000	LABORATORY	0.317623	63,237	20,086	60.00
65.00	06500	RESPIRATORY THERAPY	0.566348	15,676	8,878	65.00
66.00	06600	PHYSICAL THERAPY	0.592444	36,612	21,691	66.00
66.01	06601	PHYSICAL THERAPY SNF	0.224878	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.410620	2,412	990	68.00
69.00	06900	ELECTROCARDIOLOGY	0.220193	1,454	320	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.123542	113,975	14,081	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.641191	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.633654	87,708	55,577	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.690152	51	35	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.101597	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		346,694	128,745	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)		346,694		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-3

Component CCN: 145539 | Date/Time Prepared: 2/26/2013 2:52 pm

Title XVIII | Skilled Nursing Facility | PPS

		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		963,902		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.916185	7,021	6,433	50.00
53.00	05300	ANESTHESIOLOGY	0.734200	158	116	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.402590	92,399	37,199	54.00
56.00	05600	RADIOISOTOPE	0.188268	4,508	849	56.00
57.00	05700	CT SCAN	0.030275	62,635	1,896	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.137439	17,028	2,340	58.00
60.00	06000	LABORATORY	0.317623	324,853	103,181	60.00
65.00	06500	RESPIRATORY THERAPY	0.566348	19,916	11,279	65.00
66.00	06600	PHYSICAL THERAPY	0.592444	0	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0.224878	1,732,115	389,515	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.410620	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.220193	14,237	3,135	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.123542	426,386	52,677	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.641191	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.633654	389,172	246,600	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.690152	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.101597	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,090,428	855,220	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,090,428		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141339	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/26/2013 2:52 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,696,359	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,696,359	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	6,763,323	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	37,313	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,404,616	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	3,321,394	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,321,394	30.00
31.00	Primary payer payments	814	31.00
32.00	Subtotal (line 30 minus line 31)	3,320,580	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)	580,438	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	580,438	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	566,547	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	3,901,018	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)	3,901,018	40.00
41.00	Interim payments	4,616,801	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)	-715,783	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	90,893	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: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2013 2:52 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		5,396,911		4,846,692	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	05/25/2012	165,233		0	3.01
3.02		09/20/2012	77,618	09/20/2012	98,107	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	05/25/2012	327,998	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)		242,851		-229,891	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)		5,639,762		4,616,801	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		385,119		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		715,783	6.02
7.00	Total Medicare program liability (see instructions)		6,024,881		3,901,018	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: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2013 2:52 pm

Component CCN: 14Z339 | 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		429,394		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	05/25/2012	22,768		0	3.01
3.02		09/20/2012	10,611		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)		33,379		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)		462,773		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		56,842		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		519,615		0	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: 141339 | Component CCN: 145539 | Period: From 10/01/2011 To 09/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2013 2:52 pm

Title XVIII | Skilled Nursing Facility | PPS

		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		1,270,570		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,270,570		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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,270,570		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: 141339	Period: From 10/01/2011 To 09/30/2012	Worksheet E-1 Part II Date/Time Prepared: 2/26/2013 2:52 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	1,396	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	3,989	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	58	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	5,002	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	68,679,072	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	3,697,338	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	805,067	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	805,067	8.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	805,067	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141339 | Component CCN: 14Z339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet E-2 | Date/Time Prepared: 2/26/2013 2:52 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)	397,937	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)	130,032	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	362	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)	527,969	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	527,969	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)	527,969	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	8,354	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)	519,615	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)	519,615	0	19.00
20.00	Interim payments	462,773	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)	56,842	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	7,075	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141339	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part V Date/Time Prepared: 2/26/2013 2:52 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	6,577,379	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)	6,577,379	4.00
5.00	Primary payer payments	1,270	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	6,641,883	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)	6,641,883	19.00
20.00	Deductibles (exclude professional component)	719,878	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	5,922,005	22.00
23.00	Coinsurance	5,142	23.00
24.00	Subtotal (line 22 minus line 23)	5,916,863	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	108,018	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	108,018	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	102,358	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	6,024,881	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)	6,024,881	30.00
31.00	Interim payments	5,639,762	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)	385,119	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	89,051	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141339 Component CCN: 145539	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part VI Date/Time Prepared: 2/26/2013 2:52 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,438,033	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,438,033	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	167,463	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Allowable reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	1,270,570	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	1,270,570	15.00
16.00	Interim payments	1,270,570	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet G | Date/Time Prepared: 2/26/2013 2:52 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	4,585,296	0	0	0	1.00
2.00	Temporary investments	1,493,850	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,332,007	0	0	0	4.00
5.00	Other receivable	113,348	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,160,185	0	0	0	6.00
7.00	Inventory	668,354	0	0	0	7.00
8.00	Prepaid expenses	298,161	0	0	0	8.00
9.00	Other current assets	977,940	0	0	0	9.00
10.00	Due from other funds	10,822	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	14,319,593	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	737,345	0	0	0	12.00
13.00	Land improvements	3,208,500	0	0	0	13.00
14.00	Accumulated depreciation	-916,961	0	0	0	14.00
15.00	Buildings	23,625,333	0	0	0	15.00
16.00	Accumulated depreciation	-5,622,973	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	19,364,433	0	0	0	23.00
24.00	Accumulated depreciation	-14,861,709	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	2,110,095	0	0	0	27.00
28.00	Accumulated depreciation	-231,274	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)	27,412,789	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,529,010	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	376,034	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,905,044	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	44,637,426	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	784,947	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,746,227	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	86,170	0	0	0	40.00
41.00	Deferred income	489,666	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	39,520	0	0	0	43.00
44.00	Other current liabilities	306,155	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,452,685	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	18,161,633	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	446,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	18,607,633	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	22,060,318	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	22,577,108				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	22,577,108	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	44,637,426	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet G-1 | Date/Time Prepared: 2/26/2013 2:52 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		20,584,653		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,800,619				2.00
3.00	Total (sum of line 1 and line 2)		22,385,272		0		3.00
4.00	BIOTERRORISM GRANT	191,836		0			4.00
5.00	ROUNDING	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)		191,836		0		10.00
11.00	Subtotal (line 3 plus line 10)		22,577,108		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)		22,577,108		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet G-1 | Date/Time Prepared: 2/26/2013 2:52 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	0		0			4.00
5.00	ROUNDING	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: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/26/2013 2:52 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,205,313		6,205,313	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	206,820		206,820	5.00
6.00	Swing bed - NF	26,852		26,852	6.00
7.00	SKILLED NURSING FACILITY	968,003		968,003	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)	7,406,988		7,406,988	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)	7,406,988		7,406,988	17.00
18.00	Ancillary services	11,878,081	37,655,967	49,534,048	18.00
19.00	Outpatient services	144,163	12,497,037	12,641,200	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		0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	321,660	7,322,100	7,643,760	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	19,750,892	57,475,104	77,225,996	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,004,761		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		33,004,761		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141339 | Period: From 10/01/2011 To 09/30/2012 | Worksheet G-3 | Date/Time Prepared: 2/26/2013 2:52 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	77,225,996	1.00
2.00	Less contractual allowances and discounts on patients' accounts	45,157,394	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,068,602	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,004,761	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-936,159	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	35,882	6.00
7.00	Income from investments	141,398	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	2,252	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	168,372	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	14,434	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	HOSPITAL ACCESS IMPROVEMENT	1,592,211	24.00
24.01	SALE OF REFUSE AND JUNK	12,239	24.01
24.02	MISCELLANEOUS INCOME	2,893	24.02
24.03	GAIN ON DISPOSAL OF ASSETS	0	24.03
24.04	UNREALIZED GAINS ON INVESTMENTS	367,364	24.04
24.05	MEANINGFUL USE INCOME	597,764	24.05
25.00	Total other income (sum of lines 6-24)	2,934,809	25.00
26.00	Total (line 5 plus line 25)	1,998,650	26.00
27.00	REALIZED INVESTMENT LOSSES	198,031	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	198,031	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,800,619	29.00