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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141322	Period: From 10/01/2012 To 09/30/2013	Worksheet S Parts I-III Date/Time Prepared: 2/25/2014 10:14 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/25/2014 Time: 10:14 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ABRAHAM LINCOLN MEMORIAL HOSPITAL (141322) for the cost reporting period beginning 10/01/2012 and ending 09/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-387,546	-756,507	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-211,031	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-598,577	-756,507	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2014 9:56 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 200 STAHLHUT DRIVE	PO Box:			1.00
2.00	City: LLINCOLN	State: IL	Zip Code: 62656	County: LOGAN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ABRAHAM LINCOLN MEMORIAL HOSPITAL	141322	99914	1	02/01/2003	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ABRAHAM LINCOLN MEMORIAL HOSPITAL	14Z322	99914		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2012	09/30/2013	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0		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: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2014 9:56 am

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

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)			39.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2014 9:56 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings					
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2014 9:56 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	113,518	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

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	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: MEMORIAL HEALTH SYSTEM	Contractor's Name: NGS	Contractor's Number: 00131	141.00
142.00	Street: 701 NORTH FIRST STREET	PO Box:		142.00
143.00	City: SPRINGFIELD	State: IL	Zip Code: 62781	143.00

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

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

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

		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)	1	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2012	09/30/2013	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 2/25/2014 9:56 am

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	10/11/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-2 Part II Date/Time Prepared: 2/25/2014 9:56 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 2/25/2014 9:56 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	10/11/2013			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-3 Part I Date/Time Prepared: 2/25/2014 9:56 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	102,857.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	102,857.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	102,857.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2014 9:56 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,334	471	3,716			1.00
2.00	HMO and other (see instructions)	60	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	843	0	1,052			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,177	471	4,768			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		314	445			13.00
14.00	Total (see instructions)	3,177	785	5,213	0.00	249.37	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	249.37	27.00
28.00	Observation Bed Days		22	96			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			50			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	51			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-3 Part I Date/Time Prepared: 2/25/2014 9:56 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	608	186	1,114	1.00
2.00	HMO and other (see instructions)			12			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	608	186	1,114	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-10 | Date/Time Prepared: 2/25/2014 9:56 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.402172	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,250,668	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	2,462,269	5.00
6.00	Medicaid charges	13,448,347	6.00
7.00	Medicaid cost (line 1 times line 6)	5,408,549	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)	695,612	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	20,353	9.00
10.00	Stand-alone SCHIP charges	95,728	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	38,499	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	18,146	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)	713,758	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	3,477,658	213,167	3,690,825	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,398,617	85,730	1,484,347	21.00
22.00	Partial payment by patients approved for charity care	536,209	0	536,209	22.00
23.00	Cost of charity care (line 21 minus line 22)	862,408	85,730	948,138	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,621,751	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	640,241	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)	981,510	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	394,736	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,342,874	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,056,632	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A | Date/Time Prepared: 2/25/2014 9:56 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,051,214	3,051,214	2,351,644	5,402,858	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,446,179	1,446,179	78,072	1,524,251	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	130,578	4,044,558	4,175,136	0	4,175,136	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,562,559	5,122,787	6,685,346	-14,868	6,670,478	5.00
7.00	00700	OPERATION OF PLANT	448,864	602,023	1,050,887	0	1,050,887	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	178,309	178,309	8.00
9.00	00900	HOUSEKEEPING	384,539	206,801	591,340	-178,309	413,031	9.00
10.00	01000	DIETARY	472,083	325,239	797,322	-494,753	302,569	10.00
11.00	01100	CAFETERIA	0	0	0	492,929	492,929	11.00
13.00	01300	NURSING ADMINISTRATION	367,704	29,303	397,007	-15,960	381,047	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	251,740	256,294	508,034	-217,738	290,296	14.00
15.00	01500	PHARMACY	412,911	1,094,645	1,507,556	-1,058,965	448,591	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	380,333	109,086	489,419	0	489,419	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	36,000	36,000	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,484,635	302,377	1,787,012	599,556	2,386,568	30.00
43.00	04300	NURSERY	0	0	0	104,216	104,216	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	832,145	817,234	1,649,379	-394,262	1,255,117	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	733,061	85,291	818,352	-703,772	114,580	52.00
53.00	05300	ANESTHESIOLOGY	770,523	285,027	1,055,550	0	1,055,550	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,138,291	636,198	1,774,489	-48,230	1,726,259	54.00
60.00	06000	LABORATORY	778,349	1,028,532	1,806,881	0	1,806,881	60.00
65.00	06500	RESPIRATORY THERAPY	327,264	131,882	459,146	0	459,146	65.00
66.00	06600	PHYSICAL THERAPY	1,252,217	75,188	1,327,405	0	1,327,405	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	76,107	189	76,296	0	76,296	68.00
69.00	06900	ELECTROCARDIOLOGY	47,467	66,981	114,448	0	114,448	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	185,936	185,936	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	426,077	426,077	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,124,966	1,124,966	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	101,478	11,802	113,280	0	113,280	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,196,953	2,104,986	3,301,939	-36,000	3,265,939	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		2,414,848	2,414,848	-2,414,848	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,149,801	24,248,664	37,398,465	0	37,398,465	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	13,149,801	24,248,664	37,398,465	0	37,398,465	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A | Date/Time Prepared: 2/25/2014 9:56 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-238,155	5,164,703		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-30,517	1,493,734		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-87,644	4,087,492		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,644,392	5,026,086		5.00
7.00	00700	OPERATION OF PLANT	0	1,050,887		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	178,309		8.00
9.00	00900	HOUSEKEEPING	0	413,031		9.00
10.00	01000	DIETARY	0	302,569		10.00
11.00	01100	CAFETERIA	-104,395	388,534		11.00
13.00	01300	NURSING ADMINISTRATION	-16	381,031		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	290,296		14.00
15.00	01500	PHARMACY	0	448,591		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,732	487,687		16.00
17.00	01700	SOCIAL SERVICE	0	36,000		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,386,568		30.00
43.00	04300	NURSERY	0	104,216		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-2,800	1,252,317		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	114,580		52.00
53.00	05300	ANESTHESIOLOGY	-779,050	276,500		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,726,259		54.00
60.00	06000	LABORATORY	-25,255	1,781,626		60.00
65.00	06500	RESPIRATORY THERAPY	-885	458,261		65.00
66.00	06600	PHYSICAL THERAPY	-34,420	1,292,985		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	76,296		68.00
69.00	06900	ELECTROCARDIOLOGY	0	114,448		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	185,936		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	426,077		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,124,966		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	113,280		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,656,073	1,609,866		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,605,334	32,793,131		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118-199)	-4,605,334	32,793,131		200.00

RECLASSIFICATIONS | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A-6 | Date/Time Prepared: 2/25/2014 9:56 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS STERILE PROCESSING SALARI				
1.00	OPERATING ROOM	50.00	67,264	0	1.00
	TOTALS		67,264	0	
	B - RECLASS LABOR AND DELIVERY EXPENSES				
1.00	NURSERY	43.00	93,354	10,862	1.00
2.00	ADULTS & PEDIATRICS	30.00	537,069	62,487	2.00
	TOTALS		630,423	73,349	
	C - RECLASS SOCIAL SERVICE FEES				
1.00	SOCIAL SERVICE	17.00	0	36,000	1.00
	TOTALS		0	36,000	
	D - TO RECLASS PROPERTY INS				
1.00	OTHER CAP REL COSTS	3.00	0	14,868	1.00
	TOTALS		0	14,868	
	E - TO RECLASS DRUG EXPENSE				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,124,966	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
	TOTALS		0	1,124,966	
	F - TO RECLASS LAUNDRY EXPENSE				
1.00	LAUNDRY & LINEN SERVICE	8.00	34,626	143,683	1.00
	TOTALS		34,626	143,683	
	G - TO RECLASS MEDICAL SUPPLIES EXPENSE				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	185,936	1.00
2.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	426,077	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	612,013	
	H - TO RECLASS CAFETERIA EXPENSE				
1.00	CAFETERIA	11.00	292,433	200,496	1.00
	TOTALS		292,433	200,496	
	I - TO RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,210,302	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	70,476	2.00
	TOTALS		0	2,280,778	
	J - TO RECLASS BOND AMOR EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	129,927	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,143	2.00
	TOTALS		0	134,070	
500.00	Grand Total: Increases		1,024,746	4,620,223	500.00

RECLASSIFICATIONS | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A-6 | Date/Time Prepared: 2/25/2014 9:56 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS STERILE PROCESSING SALARI						
1.00	CENTRAL SERVICES & SUPPLY	14.00	67,264	0	0		1.00
	TOTALS		67,264	0			
	B - RECLASS LABOR AND DELIVERY EXPENSES						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	630,423	73,349	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		630,423	73,349			
	C - RECLASS SOCIAL SERVICE FEES						
1.00	EMERGENCY	91.00	0	36,000	0		1.00
	TOTALS		0	36,000			
	D - TO RECLASS PROPERTY INS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14,868	0		1.00
	TOTALS		0	14,868			
	E - TO RECLASS DRUG EXPENSE						
1.00	DIETARY	10.00	0	1,824	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	15,960	0		2.00
3.00	PHARMACY	15.00	0	1,058,952	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	48,230	0		4.00
	TOTALS		0	1,124,966			
	F - TO RECLASS LAUNDRY EXPENSE						
1.00	HOUSEKEEPING	9.00	34,626	143,683	0		1.00
	TOTALS		34,626	143,683			
	G - TO RECLASS MEDICAL SUPPLIES EXPENSE						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	150,474	0		1.00
2.00	PHARMACY	15.00	0	13	0		2.00
3.00	OPERATING ROOM	50.00	0	461,526	0		3.00
	TOTALS		0	612,013			
	H - TO RECLASS CAFETERIA EXPENSE						
1.00	DIETARY	10.00	292,433	200,496	0		1.00
	TOTALS		292,433	200,496			
	I - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	2,280,778	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	2,280,778			
	J - TO RECLASS BOND AMOR EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	134,070	14		1.00
2.00		0.00	0	0	14		2.00
	TOTALS		0	134,070			
500.00	Grand Total: Decreases		1,024,746	4,620,223			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A-7 Part I | Date/Time Prepared: 2/25/2014 9:56 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	936,822	0	0	0	101,974	1.00
2.00	Land Improvements	5,784,294	0	0	0	0	2.00
3.00	Buildings and Fixtures	41,413,367	30,734	0	30,734	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	11,866,651	793,399	0	793,399	35,843	6.00
7.00	HIT designated Assets	1,912,947	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	61,914,081	824,133	0	824,133	137,817	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	61,914,081	824,133	0	824,133	137,817	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	834,848	0	1.00
2.00	Land Improvements	5,784,294	0	2.00
3.00	Buildings and Fixtures	41,444,101	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	12,624,207	0	6.00
7.00	HIT designated Assets	1,912,947	0	7.00
8.00	Subtotal (sum of lines 1-7)	62,600,397	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	62,600,397	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A-7 Part II | Date/Time Prepared: 2/25/2014 9:56 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,051,214	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,446,179	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,497,393	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3,051,214	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,446,179	2.00
3.00	Total (sum of lines 1-2)	0	4,497,393	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A-7 Part III Date/Time Prepared: 2/25/2014 9:56 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	48,063,243	0	48,063,243	0.767779	11,415	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,537,154	0	14,537,154	0.232221	3,453	2.00
3.00	Total (sum of lines 1-2)	62,600,397	0	62,600,397	1.000000	14,868	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	11,415	3,060,630	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	3,453	1,423,556	0	2.00
3.00	Total (sum of lines 1-2)	0	0	14,868	4,484,186	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,962,731	11,415	0	129,927	5,164,703	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	62,582	3,453	0	4,143	1,493,734	2.00
3.00	Total (sum of lines 1-2)	2,025,313	14,868	0	134,070	6,658,437	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A-8 | Date/Time Prepared: 2/25/2014 9:56 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-247,571	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-7,894	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-2,379	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,678,116			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-333,715			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-104,395	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,732	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-172,465	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00			0		0.00	0	33.00
33.01			0		0.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A-8 | Date/Time Prepared: 2/25/2014 9:56 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02			0		0.00	0	33.02
33.03	NURSING ADMIN MISC REVENUE	B	-16	NURSING ADMINISTRATION	13.00	0	33.03
33.04	LAB MISC REVENUE	B	-3,212	LABORATORY	60.00	0	33.04
33.05	RESPIRATORY MISC REVENUE	B	-885	RESPIRATORY THERAPY	65.00	0	33.05
33.06	OR MISC REVENUE	B	-2,800	OPERATING ROOM	50.00	0	33.06
33.07	PHYSICAL THERAPY MISC REVENUE	B	-34,420	PHYSICAL THERAPY	66.00	0	33.07
33.08	MISC REVENUE	B	-70,046	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	MANAGEMENT FEE REVENUE	B	-14,880	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10			0		0.00	0	33.10
33.11	CRNA SALARIES	A	-770,523	ANESTHESIOLOGY	53.00	0	33.11
33.12	CRNA BENEFITS EXPENSE	A	-80,155	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	CRNA CONTRACT EXPENSE	A	-8,527	ANESTHESIOLOGY	53.00	0	33.13
33.14	MARKETING SALARY	A	-34,587	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	MARKETING BENEFITS EXPENSE	A	-7,489	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	MARKETING OTHER EXPENSE	A	-46,449	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	ADVERTISING EXPENSE	A	-52,159	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	LOBBYING EXPENSE	A	-17,149	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	PROVIDER TAX	A	-973,784	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	PROVIDER TAX ASSISTANCE PAYMENT	A	-17,376	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	FUNDED DEPRECIATION TRUSTEE FEES	A	77,390	ADMINISTRATIVE & GENERAL	5.00	0	33.21
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,605,334				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141322	Period: From 10/01/2012 To 09/30/2013	Worksheet A-8-1 Date/Time Prepared: 2/25/2014 9:56 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HO BUILDING CAPITAL	9,416	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO MME CAPITAL	149,842	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HO INTEREST OPERATING	21,242	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HO MANAGEMENT OPERATING	2,554,086	2,484,345	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	SELF INSURANCE BENEFITS	1,270,152	1,854,108	4.01
4.02	14.00	CENTRAL SERVICES & SUPPLY	PRINT SHOP & SUPPLIES - MMC	86,070	86,070	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,090,808	4,424,523	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		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	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	MEMORIAL HL SYS	100.00	6.00
7.00	B		0.00	MEMORIAL MD CTR	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141322	Period: From 10/01/2012 To 09/30/2013	Worksheet A-8-1 Date/Time Prepared: 2/25/2014 9:56 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	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	9,416	9		1.00
2.00	149,842	9		2.00
3.00	21,242	0		3.00
4.00	69,741	0		4.00
4.01	-583,956	0		4.01
4.02	0	0		4.02
5.00	-333,715			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		
	Type of Business		
	6.00		
	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	MANAGEMENT/HO		6.00
7.00	HOSPITAL		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A-8-2 | Date/Time Prepared: 2/25/2014 9:56 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	2,982	0	2,982	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	5,179	0	5,179	0	0	2.00
3.00	50.00	OPERATING ROOM	22,253	0	22,253	0	0	3.00
4.00	76.97	CARDIAC REHABILITATION	2,494	0	2,494	0	0	4.00
5.00	91.00	EMERGENCY	1,800,905	1,656,073	144,832	0	0	5.00
6.00	91.00	EMERGENCY	55,000	0	55,000	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	232,443	0	232,443	0	0	7.00
8.00	60.00	LABORATORY	22,043	22,043	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,143,299	1,678,116	465,183		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0		2.00
3.00	50.00	OPERATING ROOM	0	0	0	0		3.00
4.00	76.97	CARDIAC REHABILITATION	0	0	0	0		4.00
5.00	91.00	EMERGENCY	0	0	0	1,656,073		5.00
6.00	91.00	EMERGENCY	0	0	0	0		6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	0		7.00
8.00	60.00	LABORATORY	0	0	0	22,043		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,678,116		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B Part I Date/Time Prepared: 2/25/2014 9:56 am

		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 DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,164,703	5,164,703				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,493,734		1,493,734			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,087,492	5,103	0	4,092,595		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,026,086	364,627	232,381	511,979	6,135,073	5.00
7.00	00700	OPERATION OF PLANT	1,050,887	1,617,530	67,148	150,401	2,885,966	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	178,309	24,992	0	11,602	214,903	8.00
9.00	00900	HOUSEKEEPING	413,031	139,788	0	117,246	670,065	9.00
10.00	01000	DIETARY	302,569	187,024	23,243	60,196	573,032	10.00
11.00	01100	CAFETERIA	388,534	0	37,835	97,986	524,355	11.00
13.00	01300	NURSING ADMINISTRATION	381,031	9,028	0	123,207	513,266	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	290,296	103,064	1,152	61,813	456,325	14.00
15.00	01500	PHARMACY	448,591	56,657	922	138,355	644,525	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	487,687	79,162	0	127,439	694,288	16.00
17.00	01700	SOCIAL SERVICE	36,000	0	0	0	36,000	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,386,568	800,958	79,752	677,413	3,944,691	30.00
43.00	04300	NURSERY	104,216	16,225	6,810	31,280	158,531	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,252,317	452,076	176,363	301,366	2,182,122	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	114,580	25,341	7,486	34,391	181,798	52.00
53.00	05300	ANESTHESIOLOGY	276,500	13,259	31,693	0	321,452	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,726,259	327,379	661,854	381,408	3,096,900	54.00
60.00	06000	LABORATORY	1,781,626	196,663	51,786	260,802	2,290,877	60.00
65.00	06500	RESPIRATORY THERAPY	458,261	39,429	21,207	109,657	628,554	65.00
66.00	06600	PHYSICAL THERAPY	1,292,985	221,219	23,506	419,582	1,957,292	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	76,296	4,710	0	25,501	106,507	68.00
69.00	06900	ELECTROCARDIOLOGY	114,448	7,807	28,341	15,905	166,501	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	185,936	0	0	0	185,936	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	426,077	0	0	0	426,077	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,124,966	0	0	0	1,124,966	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	113,280	170,755	0	34,002	318,037	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,609,866	261,563	42,255	401,064	2,314,748	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,793,131	5,124,359	1,493,734	4,092,595	32,752,787	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	40,344	0	0	40,344	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	32,793,131	5,164,703	1,493,734	4,092,595	32,793,131	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B Part I | Date/Time Prepared: 2/25/2014 9:56 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,135,073					5.00
7.00	00700	OPERATION OF PLANT	664,176	3,550,142				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	49,458	27,923	292,284			8.00
9.00	00900	HOUSEKEEPING	154,209	156,185	0	980,459		9.00
10.00	01000	DIETARY	131,878	208,961	390	60,866	975,127	10.00
11.00	01100	CAFETERIA	120,675	0	636	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	118,123	10,087	0	2,938	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	105,019	115,153	619	33,542	0	14.00
15.00	01500	PHARMACY	148,331	63,302	0	18,439	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	159,783	88,448	0	25,763	0	16.00
17.00	01700	SOCIAL SERVICE	8,285	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	907,818	894,907	83,153	260,668	966,847	30.00
43.00	04300	NURSERY	36,484	18,128	2,617	5,280	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	502,194	505,102	40,318	147,126	8,280	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	41,839	28,313	2,877	8,247	0	52.00
53.00	05300	ANESTHESIOLOGY	73,979	14,814	0	4,315	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	712,721	365,779	38,561	106,544	0	54.00
60.00	06000	LABORATORY	527,222	219,731	19	64,003	0	60.00
65.00	06500	RESPIRATORY THERAPY	144,655	44,053	0	12,832	0	65.00
66.00	06600	PHYSICAL THERAPY	450,451	247,166	32,611	71,995	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	24,512	5,263	0	1,533	0	68.00
69.00	06900	ELECTROCARDIOLOGY	38,319	8,723	4,820	2,541	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,791	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	98,057	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	258,900	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	73,193	190,784	0	55,572	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	532,716	292,243	75,909	85,125	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,125,788	3,505,065	282,530	967,329	975,127	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,285	45,077	0	13,130	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	9,754	0	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	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,135,073	3,550,142	292,284	980,459	975,127	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B Part I | Date/Time Prepared: 2/25/2014 9:56 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	645,666					11.00
13.00	01300	NURSING ADMINISTRATION	19,933	664,347				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,138	1,138	731,934			14.00
15.00	01500	PHARMACY	17,323	0	924	892,844		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	42,860	0	25	0	1,011,167	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	12,687	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	146,134	265,571	52,775	0	144,699	30.00
43.00	04300	NURSERY	5,118	11,702	816	0	10,665	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,957	132,040	69,598	0	102,039	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,681	80,202	897	0	6,053	52.00
53.00	05300	ANESTHESIOLOGY	11,003	0	9,491	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,297	0	40,619	38,341	69,179	54.00
60.00	06000	LABORATORY	67,015	0	251,731	0	76,385	60.00
65.00	06500	RESPIRATORY THERAPY	21,520	0	2,727	0	21,330	65.00
66.00	06600	PHYSICAL THERAPY	74,103	0	10,767	0	22,195	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,736	0	0	0	288	68.00
69.00	06900	ELECTROCARDIOLOGY	3,736	0	389	0	21,042	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	73,251	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	167,856	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	841,816	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	5,885	0	578	0	4,900	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	76,227	173,694	49,490	0	523,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	645,666	664,347	731,934	892,844	1,001,943	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	9,224	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)	645,666	664,347	731,934	892,844	1,011,167	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B Part I | Date/Time Prepared: 2/25/2014 9:56 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
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	56,972					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	7,667,263	0	7,667,263		30.00
43.00	04300	NURSERY	0	249,341	0	249,341		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,746,776	0	3,746,776		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	355,907	0	355,907		52.00
53.00	05300	ANESTHESIOLOGY	0	435,054	0	435,054		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,535,941	0	4,535,941		54.00
60.00	06000	LABORATORY	0	3,496,983	0	3,496,983		60.00
65.00	06500	RESPIRATORY THERAPY	0	875,671	0	875,671		65.00
66.00	06600	PHYSICAL THERAPY	0	2,866,580	0	2,866,580		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	141,839	0	141,839		68.00
69.00	06900	ELECTROCARDIOLOGY	0	246,071	0	246,071		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	301,978	0	301,978		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	691,990	0	691,990		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,225,682	0	2,225,682		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	648,949	0	648,949		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	56,972	4,180,292	0	4,180,292		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	56,972	32,666,317	0	32,666,317		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	107,836	0	107,836		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	18,978	0	18,978		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	56,972	32,793,131	0	32,793,131		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B Part II Date/Time Prepared: 2/25/2014 9:56 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,103	0	5,103	5,103	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,258	364,627	232,381	613,266	639	5.00
7.00	00700	OPERATION OF PLANT	9,126	1,617,530	67,148	1,693,804	188	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	24,992	0	24,992	14	8.00
9.00	00900	HOUSEKEEPING	0	139,788	0	139,788	146	9.00
10.00	01000	DIETARY	0	187,024	23,243	210,267	75	10.00
11.00	01100	CAFETERIA	0	0	37,835	37,835	122	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,028	0	9,028	154	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	103,064	1,152	104,216	77	14.00
15.00	01500	PHARMACY	0	56,657	922	57,579	173	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	79,162	0	79,162	159	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,635	800,958	79,752	892,345	843	30.00
43.00	04300	NURSERY	0	16,225	6,810	23,035	39	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	55,274	452,076	176,363	683,713	376	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	25,341	7,486	32,827	43	52.00
53.00	05300	ANESTHESIOLOGY	3,096	13,259	31,693	48,048	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	150	327,379	661,854	989,383	476	54.00
60.00	06000	LABORATORY	75	196,663	51,786	248,524	325	60.00
65.00	06500	RESPIRATORY THERAPY	392	39,429	21,207	61,028	137	65.00
66.00	06600	PHYSICAL THERAPY	153	221,219	23,506	244,878	523	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,710	0	4,710	32	68.00
69.00	06900	ELECTROCARDIOLOGY	1,690	7,807	28,341	37,838	20	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	170,755	0	170,755	42	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	261,563	42,255	303,818	500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	97,849	5,124,359	1,493,734	6,715,942	5,103	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	40,344	0	40,344	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	97,849	5,164,703	1,493,734	6,756,286	5,103	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B Part II | Date/Time Prepared: 2/25/2014 9:56 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	613,905					5.00
7.00	00700	OPERATION OF PLANT	66,461	1,760,453				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,949	13,847	43,802			8.00
9.00	00900	HOUSEKEEPING	15,431	77,449	0	232,814		9.00
10.00	01000	DIETARY	13,196	103,620	59	14,453	341,670	10.00
11.00	01100	CAFETERIA	12,075	0	95	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	11,820	5,002	0	698	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,509	57,102	93	7,965	0	14.00
15.00	01500	PHARMACY	14,843	31,390	0	4,378	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,989	43,860	0	6,118	0	16.00
17.00	01700	SOCIAL SERVICE	829	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	90,838	443,770	12,461	61,896	338,769	30.00
43.00	04300	NURSERY	3,651	8,989	392	1,254	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,252	250,471	6,042	34,936	2,901	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,187	14,040	431	1,958	0	52.00
53.00	05300	ANESTHESIOLOGY	7,403	7,346	0	1,025	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	71,319	181,383	5,779	25,299	0	54.00
60.00	06000	LABORATORY	52,757	108,961	3	15,198	0	60.00
65.00	06500	RESPIRATORY THERAPY	14,475	21,845	0	3,047	0	65.00
66.00	06600	PHYSICAL THERAPY	45,074	122,565	4,887	17,095	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,453	2,610	0	364	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,834	4,326	722	603	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,282	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	9,812	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,907	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	7,324	94,606	0	13,196	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	53,306	144,918	11,376	20,213	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	612,976	1,738,100	42,340	229,696	341,670	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	929	22,353	0	3,118	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,462	0	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	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	613,905	1,760,453	43,802	232,814	341,670	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B Part II | Date/Time Prepared: 2/25/2014 9:56 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	50,127					11.00
13.00	01300	NURSING ADMINISTRATION	1,548	28,250				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,563	48	181,573			14.00
15.00	01500	PHARMACY	1,345	0	229	109,937		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,327	0	6	0	148,621	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	1,562	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,345	11,293	13,092	0	21,268	30.00
43.00	04300	NURSERY	397	498	202	0	1,568	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,500	5,615	17,265	0	14,998	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	441	3,410	223	0	890	52.00
53.00	05300	ANESTHESIOLOGY	854	0	2,354	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,225	0	10,077	4,721	10,168	54.00
60.00	06000	LABORATORY	5,203	0	62,448	0	11,227	60.00
65.00	06500	RESPIRATORY THERAPY	1,671	0	676	0	3,135	65.00
66.00	06600	PHYSICAL THERAPY	5,753	0	2,671	0	3,262	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	290	0	0	0	42	68.00
69.00	06900	ELECTROCARDIOLOGY	290	0	97	0	3,093	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	18,172	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	41,641	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	103,654	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	457	0	143	0	720	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,918	7,386	12,277	0	76,894	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	50,127	28,250	181,573	109,937	147,265	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,356	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)	50,127	28,250	181,573	109,937	148,621	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B Part II | Date/Time Prepared: 2/25/2014 9:56 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
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	2,391					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,897,920	0	1,897,920		30.00
43.00	04300	NURSERY	0	40,025	0	40,025		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,071,069	0	1,071,069		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	58,450	0	58,450		52.00
53.00	05300	ANESTHESIOLOGY	0	67,030	0	67,030		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,303,830	0	1,303,830		54.00
60.00	06000	LABORATORY	0	504,646	0	504,646		60.00
65.00	06500	RESPIRATORY THERAPY	0	106,014	0	106,014		65.00
66.00	06600	PHYSICAL THERAPY	0	446,708	0	446,708		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	10,501	0	10,501		68.00
69.00	06900	ELECTROCARDIOLOGY	0	50,823	0	50,823		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,454	0	22,454		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	51,453	0	51,453		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	129,561	0	129,561		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	287,243	0	287,243		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,391	638,997	0	638,997		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,391	6,686,724	0	6,686,724		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	66,744	0	66,744		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,818	0	2,818		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	2,391	6,756,286	0	6,756,286		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B-1 | Date/Time Prepared: 2/25/2014 9:56 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	118,414					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,490,281				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	117	0	12,214,113			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,360	231,844	1,527,972	-6,135,073	26,658,058	5.00
7.00	00700	OPERATION OF PLANT	37,086	66,993	448,864	0	2,885,966	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	573	0	34,626	0	214,903	8.00
9.00	00900	HOUSEKEEPING	3,205	0	349,913	0	670,065	9.00
10.00	01000	DIETARY	4,288	23,189	179,650	0	573,032	10.00
11.00	01100	CAFETERIA	0	37,748	292,433	0	524,355	11.00
13.00	01300	NURSING ADMINISTRATION	207	0	367,704	0	513,266	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,363	1,149	184,476	0	456,325	14.00
15.00	01500	PHARMACY	1,299	920	412,911	0	644,525	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,815	0	380,333	0	694,288	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	36,000	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,364	79,568	2,021,704	0	3,944,691	30.00
43.00	04300	NURSERY	372	6,794	93,354	0	158,531	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,365	175,955	899,409	0	2,182,122	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	581	7,469	102,638	0	181,798	52.00
53.00	05300	ANESTHESIOLOGY	304	31,620	0	0	321,452	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,506	660,324	1,138,291	0	3,096,900	54.00
60.00	06000	LABORATORY	4,509	51,666	778,349	0	2,290,877	60.00
65.00	06500	RESPIRATORY THERAPY	904	21,158	327,264	0	628,554	65.00
66.00	06600	PHYSICAL THERAPY	5,072	23,452	1,252,217	0	1,957,292	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	108	0	76,107	0	106,507	68.00
69.00	06900	ELECTROCARDIOLOGY	179	28,275	47,467	0	166,501	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	185,936	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	426,077	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,124,966	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,915	0	101,478	0	318,037	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,997	42,157	1,196,953	0	2,314,748	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	117,489	1,490,281	12,214,113	-6,135,073	26,617,714	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	925	0	0	0	40,344	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,164,703	1,493,734	4,092,595		6,135,073	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	43.615645	1.002317	0.335071		0.230140	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,103		613,905	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000418		0.023029	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B-1 | Date/Time Prepared: 2/25/2014 9:56 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	72,851					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	573	369,762				8.00
9.00	00900	HOUSEKEEPING	3,205	0	69,073			9.00
10.00	01000	DIETARY	4,288	494	4,288	22,375		10.00
11.00	01100	CAFETERIA	0	804	0	0	25,233	11.00
13.00	01300	NURSING ADMINISTRATION	207	0	207	0	779	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,363	783	2,363	0	787	14.00
15.00	01500	PHARMACY	1,299	0	1,299	0	677	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,815	0	1,815	0	1,675	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,364	105,193	18,364	22,185	5,711	30.00
43.00	04300	NURSERY	372	3,311	372	0	200	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,365	51,006	10,365	190	2,265	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	581	3,640	581	0	222	52.00
53.00	05300	ANESTHESIOLOGY	304	0	304	0	430	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,506	48,783	7,506	0	2,630	54.00
60.00	06000	LABORATORY	4,509	24	4,509	0	2,619	60.00
65.00	06500	RESPIRATORY THERAPY	904	0	904	0	841	65.00
66.00	06600	PHYSICAL THERAPY	5,072	41,256	5,072	0	2,896	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	108	0	108	0	146	68.00
69.00	06900	ELECTROCARDIOLOGY	179	6,098	179	0	146	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,915	0	3,915	0	230	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,997	96,031	5,997	0	2,979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	71,926	357,423	68,148	22,375	25,233	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	925	0	925	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,339	0	0	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)	3,550,142	292,284	980,459	975,127	645,666	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	48.731548	0.790465	14.194533	43.581095	25.588158	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,760,453	43,802	232,814	341,670	50,127	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	24.165118	0.118460	3.370550	15.270168	1.986565	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B-1 | Date/Time Prepared: 2/25/2014 9:56 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	162,363					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	278	1,857,908				14.00
15.00	01500	PHARMACY	0	2,346	1,123,142			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	63	0	3,508		16.00
17.00	01700	SOCIAL SERVICE	0	0	15,960	0	340	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	64,904	133,961	0	502	0	30.00
43.00	04300	NURSERY	2,860	2,071	0	37	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,270	176,665	0	354	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,601	2,277	0	21	0	52.00
53.00	05300	ANESTHESIOLOGY	0	24,091	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	103,106	48,230	240	0	54.00
60.00	06000	LABORATORY	0	638,986	0	265	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,921	0	74	0	65.00
66.00	06600	PHYSICAL THERAPY	0	27,330	0	77	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	988	0	73	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	185,936	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	426,077	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,058,952	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,468	0	17	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	42,450	125,622	0	1,815	340	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	162,363	1,857,908	1,123,142	3,476	340	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	32	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)	664,347	731,934	892,844	1,011,167	56,972	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.091739	0.393956	0.794952	288.246009	167.564706	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	28,250	181,573	109,937	148,621	2,391	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.173993	0.097730	0.097883	42.366306	7.032353	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet C Part I Date/Time Prepared: 2/25/2014 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,667,263		7,667,263	0	7,667,263	30.00
43.00	04300	NURSERY	249,341		249,341	0	249,341	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,746,776		3,746,776	0	3,746,776	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	355,907		355,907	0	355,907	52.00
53.00	05300	ANESTHESIOLOGY	435,054		435,054	0	435,054	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,535,941		4,535,941	0	4,535,941	54.00
60.00	06000	LABORATORY	3,496,983		3,496,983	0	3,496,983	60.00
65.00	06500	RESPIRATORY THERAPY	875,671	0	875,671	0	875,671	65.00
66.00	06600	PHYSICAL THERAPY	2,866,580	0	2,866,580	0	2,866,580	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	141,839	0	141,839	0	141,839	68.00
69.00	06900	ELECTROCARDIOLOGY	246,071		246,071	0	246,071	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	301,978		301,978	0	301,978	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	691,990		691,990	0	691,990	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,225,682		2,225,682	0	2,225,682	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	648,949		648,949	0	648,949	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,180,292		4,180,292	0	4,180,292	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	151,328		151,328		151,328	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	32,817,645	0	32,817,645	0	32,817,645	200.00
201.00		Less Observation Beds	151,328		151,328		151,328	201.00
202.00		Total (see instructions)	32,666,317	0	32,666,317	0	32,666,317	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet C Part I Date/Time Prepared: 2/25/2014 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,988,272		4,988,272			30.00
43.00	04300	NURSERY	320,763		320,763			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,428,662	5,211,147	6,639,809	0.564290	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	840,427	887,161	1,727,588	0.206014	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	371,216	863,138	1,234,354	0.352455	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,213,802	23,132,129	24,345,931	0.186312	0.000000	54.00
60.00	06000	LABORATORY	1,923,655	10,361,003	12,284,658	0.284663	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	637,115	1,218,180	1,855,295	0.471985	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	567,241	4,279,512	4,846,753	0.591443	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	49,927	189,881	239,808	0.591469	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	395,540	921,705	1,317,245	0.186807	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,001,744	1,091,812	2,093,556	0.144242	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,463,543	607,023	2,070,566	0.334203	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,664,457	5,088,662	7,753,119	0.287069	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	447,902	447,902	1.448864	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	203,349	8,736,133	8,939,482	0.467621	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,492	118,202	119,694	1.264291	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,071,205	63,153,590	81,224,795			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	18,071,205	63,153,590	81,224,795			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet C Part I Date/Time Prepared: 2/25/2014 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D Part II Date/Time Prepared: 2/25/2014 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,071,069	6,639,809	0.161310	431,376	69,585	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	58,450	1,727,588	0.033833	430	15	52.00
53.00	05300	ANESTHESIOLOGY	67,030	1,234,354	0.054304	101,598	5,517	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,303,830	24,345,931	0.053554	828,660	44,378	54.00
60.00	06000	LABORATORY	504,646	12,284,658	0.041079	1,097,385	45,079	60.00
65.00	06500	RESPIRATORY THERAPY	106,014	1,855,295	0.057141	407,517	23,286	65.00
66.00	06600	PHYSICAL THERAPY	446,708	4,846,753	0.092166	241,719	22,278	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,501	239,808	0.043789	33,116	1,450	68.00
69.00	06900	ELECTROCARDIOLOGY	50,823	1,317,245	0.038583	271,329	10,469	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,454	2,093,556	0.010725	535,348	5,742	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	51,453	2,070,566	0.024850	650,992	16,177	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	129,561	7,753,119	0.016711	1,205,000	20,137	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	287,243	447,902	0.641308	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	638,997	8,939,482	0.071480	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	119,694	0.000000	1,492	0	92.00
200.00		Total (lines 50-199)	4,748,779	75,915,760		5,805,962	264,113	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D Part IV | Date/Time Prepared: 2/25/2014 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D Part IV | Date/Time Prepared: 2/25/2014 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,639,809	0.000000	0.000000	431,376	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,727,588	0.000000	0.000000	430	52.00
53.00	05300	ANESTHESIOLOGY	0	1,234,354	0.000000	0.000000	101,598	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,345,931	0.000000	0.000000	828,660	54.00
60.00	06000	LABORATORY	0	12,284,658	0.000000	0.000000	1,097,385	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,855,295	0.000000	0.000000	407,517	65.00
66.00	06600	PHYSICAL THERAPY	0	4,846,753	0.000000	0.000000	241,719	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	239,808	0.000000	0.000000	33,116	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,317,245	0.000000	0.000000	271,329	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,093,556	0.000000	0.000000	535,348	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	2,070,566	0.000000	0.000000	650,992	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,753,119	0.000000	0.000000	1,205,000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	447,902	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	8,939,482	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	119,694	0.000000	0.000000	1,492	92.00
200.00		Total (lines 50-199)	0	75,915,760			5,805,962	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D Part IV | Date/Time Prepared: 2/25/2014 9:56 am

Title XVIII | Hospital | Cost

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D Part V Date/Time Prepared: 2/25/2014 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.564290	0	1,804,729	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.206014	0	2,523	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.352455	0	189,216	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186312	0	8,303,311	0	0	54.00
60.00	06000	LABORATORY	0.284663	0	3,918,786	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.471985	0	386,044	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.591443	0	1,501,635	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.591469	0	16,773	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.186807	0	424,688	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.144242	0	322,659	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.334203	0	267,029	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.287069	0	2,321,702	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.448864	0	259,816	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.467621	0	2,460,458	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.264291	0	50,407	0	0	92.00
200.00		Subtotal (see instructions)		0	22,229,776	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	22,229,776	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D Part V Date/Time Prepared: 2/25/2014 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,018,391	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	520	0		52.00
53.00	05300	ANESTHESIOLOGY	66,690	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,547,006	0		54.00
60.00	06000	LABORATORY	1,115,533	0		60.00
65.00	06500	RESPIRATORY THERAPY	182,207	0		65.00
66.00	06600	PHYSICAL THERAPY	888,132	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	9,921	0		68.00
69.00	06900	ELECTROCARDIOLOGY	79,335	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	46,541	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	89,242	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	666,489	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	376,438	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,150,562	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	63,729	0		92.00
200.00		Subtotal (see instructions)	7,300,736	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	7,300,736	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141322 | Component CCN: 14Z322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D Part V | Date/Time Prepared: 2/25/2014 9:56 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.564290	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.206014	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.352455	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186312	0	0	0	0	54.00
60.00	06000	LABORATORY	0.284663	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.471985	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.591443	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.591469	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.186807	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.144242	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.334203	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.287069	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.448864	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.467621	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.264291	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141322 | Component CCN: 14Z322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D Part V | Date/Time Prepared: 2/25/2014 9:56 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D-1 | Date/Time Prepared: 2/25/2014 9:56 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,864	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,812	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,716	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	348	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)	704	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)	2,334	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)	211	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)	632	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	120.63	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	120.63	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,667,263	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)	1,658,299	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,008,964	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,008,964	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)	1,576.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,679,154	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)	3,679,154	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D-1 | Date/Time Prepared: 2/25/2014 9:56 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,794,258	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,473,412	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)	332,606	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	996,241	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,328,847	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)	96	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,576.33	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	151,328	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D-1 | Date/Time Prepared: 2/25/2014 9:56 am

Title XVIII | Hospital | Cost

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D-3 | Date/Time Prepared: 2/25/2014 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,644,059		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.564290	431,376	243,421	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.206014	430	89	52.00
53.00	05300	ANESTHESIOLOGY	0.352455	101,598	35,809	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186312	828,660	154,389	54.00
60.00	06000	LABORATORY	0.284663	1,097,385	312,385	60.00
65.00	06500	RESPIRATORY THERAPY	0.471985	407,517	192,342	65.00
66.00	06600	PHYSICAL THERAPY	0.591443	241,719	142,963	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.591469	33,116	19,587	68.00
69.00	06900	ELECTROCARDIOLOGY	0.186807	271,329	50,686	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.144242	535,348	77,220	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.334203	650,992	217,563	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.287069	1,205,000	345,918	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.448864	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.467621	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.264291	1,492	1,886	92.00
200.00		Total (sum of lines 50-94 and 96-98)		5,805,962	1,794,258	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		5,805,962		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D-3

Component CCN: 14Z322 | Date/Time Prepared: 2/25/2014 9:56 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.564290	1,500	846	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.206014	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.352455	664	234	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.186312	80,443	14,987	54.00
60.00	06000	LABORATORY	0.284663	177,050	50,400	60.00
65.00	06500	RESPIRATORY THERAPY	0.471985	112,863	53,270	65.00
66.00	06600	PHYSICAL THERAPY	0.591443	182,697	108,055	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.591469	8,599	5,086	68.00
69.00	06900	ELECTROCARDIOLOGY	0.186807	15,154	2,831	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.144242	138,903	20,036	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.334203	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.287069	294,857	84,644	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.448864	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.467621	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.264291	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,012,730	340,389	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,012,730		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141322	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part B Date/Time Prepared: 2/25/2014 9:56 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,300,736	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)	7,300,736	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)	7,373,743	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)	57,401	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,672,507	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)	3,643,835	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)	3,643,835	30.00
31.00	Primary payer payments	392	31.00
32.00	Subtotal (line 30 minus line 31)	3,643,443	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)	632,431	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	556,539	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	580,335	36.00
37.00	Subtotal (see instructions)	4,199,982	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,199,982	40.00
40.01	Sequestration adjustment (see instructions)	42,000	40.01
41.00	Interim payments	4,914,489	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-756,507	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 2/25/2014 9:56 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,654,213		5,290,382	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	03/25/2013	187,905	03/25/2013	205,757	3.50
3.51		09/23/2013	64,301	09/23/2013	170,136	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)		-252,206		-375,893	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)		5,402,007		4,914,489	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		387,546		756,507	6.02
7.00	Total Medicare program liability (see instructions)		5,014,461		4,157,982	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 2/25/2014 9:56 am

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

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,936,401		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	03/25/2013	46,404		0	3.50
3.51		09/23/2013	15,141		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)		-61,545		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)		1,874,856		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		211,031		0	6.02
7.00	Total Medicare program liability (see instructions)		1,663,825		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141322	Period: From 10/01/2012 To 09/30/2013	Worksheet E-1 Part II Date/Time Prepared: 2/25/2014 9:56 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	1,114	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	2,334	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	60	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	3,716	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	81,224,795	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	3,690,825	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	1	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	1	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141322 | Component CCN: 14Z322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet E-2 | Date/Time Prepared: 2/25/2014 9:56 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,342,135	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)	343,793	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	843	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,685,928	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,685,928	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,685,928	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,297	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,680,631	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,680,631	0	19.00
19.01	Sequestration adjustment (see instructions)	16,806	0	19.01
20.00	Interim payments	1,874,856	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	-211,031	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141322	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part V Date/Time Prepared: 2/25/2014 9:56 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	5,473,412	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	5,473,412	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,528,146	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	5,528,146	19.00
20.00	Deductibles (exclude professional component)	545,848	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	4,982,298	22.00
23.00	Coinsurance	888	23.00
24.00	Subtotal (line 22 minus line 23)	4,981,410	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	95,116	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	83,702	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	82,624	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,065,112	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	5,065,112	30.00
30.01	Sequestration adjustment (see instructions)	50,651	30.01
31.00	Interim payments	5,402,007	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32	-387,546	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet G | Date/Time Prepared: 2/25/2014 9:56 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	17,784,018	0	0	0	1.00
2.00	Temporary investments	1,789,999	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,229,424	0	0	0	4.00
5.00	Other receivable	1,222,646	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,632,343	0	0	0	6.00
7.00	Inventory	514,498	0	0	0	7.00
8.00	Prepaid expenses	172,530	0	0	0	8.00
9.00	Other current assets	1,138,378	0	0	0	9.00
10.00	Due from other funds	169,300	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	29,388,450	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	834,848	0	0	0	12.00
13.00	Land improvements	5,784,294	0	0	0	13.00
14.00	Accumulated depreciation	-1,305,376	0	0	0	14.00
15.00	Buildings	41,613,228	0	0	0	15.00
16.00	Accumulated depreciation	-7,053,409	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	12,624,208	0	0	0	23.00
24.00	Accumulated depreciation	-8,123,170	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	1,912,947	0	0	0	27.00
28.00	Accumulated depreciation	-419,438	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	45,868,132	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	15,742,647	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	797,699	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	16,540,346	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	91,796,928	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	692,033	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,130,181	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,326,560	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	4,508,912	0	0	0	43.00
44.00	Other current liabilities	533,972	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,191,658	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	42,192,132	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	42,192,132	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	50,383,790	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	41,413,138				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)	41,413,138	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	91,796,928	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet G-1 | Date/Time Prepared: 2/25/2014 9:56 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		34,958,844		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,459,315				2.00
3.00	Total (sum of line 1 and line 2)		41,418,159		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		41,418,159		0		11.00
12.00	ASSETS RELEASED FROM RESTRICTIONS	5,021		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		5,021		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		41,413,138		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/25/2014 9:56 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,991,371		3,991,371	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	556,165		556,165	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,547,536		4,547,536	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,547,536		4,547,536	17.00
18.00	Ancillary services	13,479,433	55,234,545	68,713,978	18.00
19.00	Outpatient services	206,277	8,912,080	9,118,357	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PROFESSIONAL CHARGES	868,584	7,309,993	8,178,577	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	19,101,830	71,456,618	90,558,448	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		37,398,465		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)		37,398,465		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141322 | Period: From 10/01/2012 To 09/30/2013 | Worksheet G-3 | Date/Time Prepared: 2/25/2014 9:56 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	90,558,448	1.00
2.00	Less contractual allowances and discounts on patients' accounts	52,336,136	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,222,312	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	37,398,465	4.00
5.00	Net income from service to patients (line 3 minus line 4)	823,847	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	173,898	6.00
7.00	Income from investments	827,669	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	104,395	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	1,732	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	2,951,355	23.00
24.00	MISCELLANEOUS INCOME	111,385	24.00
24.01	MEANINGFUL USE INCOME	575,019	24.01
24.02	MANAGEMENT SUPPORT	14,880	24.02
24.03	GAIN ON SALE OF FIXED ASSETS	236,119	24.03
24.04	UNREALIZED GAINS	716,406	24.04
25.00	Total other income (sum of lines 6-24)	5,712,858	25.00
26.00	Total (line 5 plus line 25)	6,536,705	26.00
27.00	TRUSTEE FEES	77,390	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	77,390	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,459,315	29.00