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: 141339	Period: From 10/01/2012 To 09/30/2013	Worksheet S Parts I-III Date/Time Prepared: 2/25/2014 2:45 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/25/2014 Time: 2:45 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by TAYLORVILLE MEMORIAL HOSPITAL (141339) for the cost reporting period beginning 10/01/2012 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	181,018	-2,649	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	-1,583	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	-1,032	0		0	7.00
200.00	Total	0	178,403	-2,649	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2014 2:31 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 201 EAST PLEASANT STREET	PO Box:			1.00
2.00	City: TAYLORVILLE	State: IL	Zip Code: 62568	County: CHRISTIAN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	TAYLORVILLE MEMORIAL HOSPITAL	141339	99914	1	09/01/2004	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	TAYLORVILLE MEMORIAL-SWB	14Z339	99914		09/01/2004	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	TAYLORVILLE SKILLED NURSING FACILITY	145539	99914		07/01/1966	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2012	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.	3	N	23.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2014 2:31 pm

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

		Y/N	Y/N	
		1.00	2.00	
39.00	Does 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: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2014 2:31 pm

		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: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2014 2:31 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
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)	N		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)	N		0	76.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2014 2:31 pm

		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	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.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	88,519	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141339	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part I Date/Time Prepared: 2/25/2014 2:31 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: MEMORIAL HEALTH SYSTEMS	Contractor's Name: MEMORIAL HEALTH SERVICES	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: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 2/25/2014 2:31 pm

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

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

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

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

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

			Part A		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: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 2/25/2014 2:31 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				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: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 2/25/2014 2:31 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	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: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-3 Part I Date/Time Prepared: 2/25/2014 2:31 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	120,949.09	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	120,949.09	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						13.00
14.00	Total (see instructions)		25	9,125	120,949.09	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	44.00	20	7,300		0	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)		45				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: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2014 2:31 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,344	298	4,770			1.00
2.00	HMO and other (see instructions)	164	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	230	0	367			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)	3,574	298	5,137			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)	3,574	298	5,137	0.00	261.76	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	2,676	0	4,183	0.00	17.64	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	279.40	27.00
28.00	Observation Bed Days		75	273			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			57			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2014 2:31 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	875	119	1,362	1.00
2.00	HMO and other (see instructions)			36			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	875	119	1,362	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-7 | Date/Time Prepared: 2/25/2014 2:31 pm

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	121	0	121	12.00
13.00		RUB	143	0	143	13.00
14.00		RUA	215	0	215	14.00
15.00		RVC	391	0	391	15.00
16.00		RVB	570	0	570	16.00
17.00		RVA	627	0	627	17.00
18.00		RHC	175	0	175	18.00
19.00		RHB	198	0	198	19.00
20.00		RHA	164	0	164	20.00
21.00		RMC	14	0	14	21.00
22.00		RMB	22	0	22	22.00
23.00		RMA	14	0	14	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	3	0	3	32.00
33.00		HC2	14	0	14	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	1	0	1	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	3	0	3	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-7 | Date/Time Prepared: 2/25/2014 2:31 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	1	0	1	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		2,676	0	2,676	200.00

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

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	743,938	84.55	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	653	0.07	Y	205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	879,847			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet S-10 | Date/Time Prepared: 2/25/2014 2:31 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.405653	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,158,319	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,834,598	5.00
6.00	Medicaid charges	9,679,865	6.00
7.00	Medicaid cost (line 1 times line 6)	3,926,666	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	32,154	9.00
10.00	Stand-alone SCHIP charges	106,298	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	43,120	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	10,966	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)	10,966	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	3,215,248	455,720	3,670,968	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,304,275	184,864	1,489,139	21.00
22.00	Partial payment by patients approved for charity care	332,351	0	332,351	22.00
23.00	Cost of charity care (line 21 minus line 22)	971,924	184,864	1,156,788	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)	434,569	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	853,971	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)	-419,402	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	-170,132	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	986,656	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	997,622	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A | Date/Time Prepared: 2/25/2014 2:31 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,364,369	1,364,369	961,477	2,325,846	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,632,306	1,632,306	101,611	1,733,917	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	117,064	3,352,568	3,469,632	0	3,469,632	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,813,052	4,809,182	6,622,234	-28,167	6,594,067	5.00
6.00	00600	MAINTENANCE & REPAIRS	-18,423	0	-18,423	0	-18,423	6.00
7.00	00700	OPERATION OF PLANT	739,669	1,007,594	1,747,263	0	1,747,263	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	89,513	68,092	157,605	0	157,605	8.00
9.00	00900	HOUSEKEEPING	356,958	98,437	455,395	0	455,395	9.00
10.00	01000	DIETARY	453,961	460,244	914,205	-600,450	313,755	10.00
11.00	01100	CAFETERIA	0	0	0	600,450	600,450	11.00
13.00	01300	NURSING ADMINISTRATION	426,109	56,678	482,787	0	482,787	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	45,614	204,561	250,175	-65,577	184,598	14.00
15.00	01500	PHARMACY	395,280	1,014,132	1,409,412	-965,125	444,287	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	461,552	59,014	520,566	0	520,566	16.00
17.00	01700	SOCIAL SERVICE	37,505	2,914	40,419	0	40,419	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,907,146	235,589	2,142,735	-233	2,142,502	30.00
44.00	04400	SKILLED NURSING FACILITY	743,938	400,907	1,144,845	-322,467	822,378	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	601,726	610,294	1,212,020	-342,444	869,576	50.00
53.00	05300	ANESTHESIOLOGY	573,143	339,208	912,351	-912	911,439	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,032,895	934,048	1,966,943	-4,288	1,962,655	54.00
60.00	06000	LABORATORY	870,753	1,234,531	2,105,284	-246	2,105,038	60.00
65.00	06500	RESPIRATORY THERAPY	435,839	157,332	593,171	-44,998	548,173	65.00
66.00	06600	PHYSICAL THERAPY	758,997	84,200	843,197	0	843,197	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	322,467	322,467	66.01
68.00	06800	SPEECH PATHOLOGY	98,975	9,827	108,802	0	108,802	68.00
69.00	06900	ELECTROCARDIOLOGY	137,832	21,820	159,652	0	159,652	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	32,569	46,502	79,071	326,205	405,276	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	157,738	157,738	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	958,104	958,104	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,471,447	1,980,803	3,452,250	-18,224	3,434,026	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,034,921	1,034,921	-1,034,921	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,583,114	21,220,073	34,803,187	0	34,803,187	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,294	1,779	4,073	0	4,073	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	13,585,408	21,221,852	34,807,260	0	34,807,260	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A | Date/Time Prepared: 2/25/2014 2:31 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-48,093	2,277,753		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-99,544	1,634,373		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-188,453	3,281,179		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-792,775	5,801,292		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	-18,423		6.00
7.00	00700	OPERATION OF PLANT	0	1,747,263		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	157,605		8.00
9.00	00900	HOUSEKEEPING	0	455,395		9.00
10.00	01000	DIETARY	0	313,755		10.00
11.00	01100	CAFETERIA	-182,885	417,565		11.00
13.00	01300	NURSING ADMINISTRATION	-6,350	476,437		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	184,598		14.00
15.00	01500	PHARMACY	0	444,287		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-11,211	509,355		16.00
17.00	01700	SOCIAL SERVICE	0	40,419		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-10,563	2,131,939		30.00
44.00	04400	SKILLED NURSING FACILITY	-5,720	816,658		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-5,200	864,376		50.00
53.00	05300	ANESTHESIOLOGY	-872,175	39,264		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-28,497	1,934,158		54.00
60.00	06000	LABORATORY	-8,333	2,096,705		60.00
65.00	06500	RESPIRATORY THERAPY	-4,200	543,973		65.00
66.00	06600	PHYSICAL THERAPY	0	843,197		66.00
66.01	06601	PHYSICAL THERAPY SNF	0	322,467		66.01
68.00	06800	SPEECH PATHOLOGY	0	108,802		68.00
69.00	06900	ELECTROCARDIOLOGY	-1,894	157,758		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	405,276		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	157,738		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	958,104		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,534,847	1,899,179		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,800,740	31,002,447		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,073		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-3,800,740	31,006,520		200.00

RECLASSIFICATIONS | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A-6 | Date/Time Prepared: 2/25/2014 2:31 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS CAFETERIA EXPENSES					
1.00	CAFETERIA	11.00	298,162	302,288		1.00
	TOTALS		298,162	302,288		
	B - TO RECLASS BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	958,104		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	TOTALS		0	958,104		
	D - TO RECLASS BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	326,205		1.00
2.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	157,738		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	TOTALS		0	483,943		
	E - TO RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	28,167		1.00
	TOTALS		0	28,167		
	F - TO RECLASS SNF THERAPY EXPENSE					
1.00	PHYSICAL THERAPY SNF	66.01	0	322,467		1.00
	TOTALS		0	322,467		
	G - TO RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	945,598		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	89,323		2.00
	TOTALS		0	1,034,921		
500.00	Grand Total: Increases		298,162	3,129,890		500.00

RECLASSIFICATIONS | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A-6 | Date/Time Prepared: 2/25/2014 2:31 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS CAFETERIA EXPENSES						
1.00	DIETARY	10.00	298,162	302,288	0		1.00
	TOTALS		298,162	302,288			
	B - TO RECLASS BILLABLE DRUGS						
1.00	PHARMACY	15.00	0	955,945	0		1.00
2.00	OPERATING ROOM	50.00	0	945	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	912	0		3.00
4.00	LABORATORY	60.00	0	246	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	56	0		5.00
	TOTALS		0	958,104			
	D - TO RECLASS BILLABLE SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	65,577	0		1.00
2.00	PHARMACY	15.00	0	9,180	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	233	0		3.00
4.00	OPERATING ROOM	50.00	0	341,499	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,288	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	44,942	0		6.00
7.00	EMERGENCY	91.00	0	18,224	0		7.00
	TOTALS		0	483,943			
	E - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	28,167	0		1.00
	TOTALS		0	28,167			
	F - TO RECLASS SNF THERAPY EXPENSE						
1.00	SKILLED NURSING FACILITY	44.00	0	322,467	0		1.00
	TOTALS		0	322,467			
	G - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,034,921	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	1,034,921			
500.00	Grand Total: Decreases		298,162	3,129,890			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A-7 Part I | Date/Time Prepared: 2/25/2014 2:31 pm

		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	737,345	0	0	0	0	1.00
2.00	Land Improvements	3,208,500	19,398	0	19,398	0	2.00
3.00	Buildings and Fixtures	22,807,297	1,859,262	0	1,859,262	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	19,364,433	682,162	0	682,162	0	6.00
7.00	HIT designated Assets	2,110,095	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	48,227,670	2,560,822	0	2,560,822	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	48,227,670	2,560,822	0	2,560,822	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	737,345	0	1.00
2.00	Land Improvements	3,227,898	0	2.00
3.00	Buildings and Fixtures	24,666,559	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	20,046,595	0	6.00
7.00	HIT designated Assets	2,110,095	0	7.00
8.00	Subtotal (sum of lines 1-7)	50,788,492	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	50,788,492	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A-7 Part II | Date/Time Prepared: 2/25/2014 2:31 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,364,369	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,632,306	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,996,675	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	1,364,369	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,632,306	2.00
3.00	Total (sum of lines 1-2)	0	2,996,675	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A-7 Part III Date/Time Prepared: 2/25/2014 2:31 pm

	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	28,631,802	0	28,631,802	0.563746	15,879	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	22,156,690	0	22,156,690	0.436254	12,288	2.00
3.00	Total (sum of lines 1-2)	50,788,492	0	50,788,492	1.000000	28,167	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	15,879	1,373,137	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	12,288	1,538,483	0	2.00
3.00	Total (sum of lines 1-2)	0	0	28,167	2,911,620	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	888,737	15,879	0	0	2,277,753	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	83,602	12,288	0	0	1,634,373	2.00
3.00	Total (sum of lines 1-2)	972,339	28,167	0	0	3,912,126	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A-8 | Date/Time Prepared: 2/25/2014 2:31 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-56,861	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-5,721	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-1,267	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-1,833	ADMINISTRATIVE & GENERAL	5.00	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	-1,817,840			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-5,997	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	184,318			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-182,885	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	-11,211	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	*** Cost Center Deleted ***	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	-233,343	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	PROVIDER TAX EXPENSE	A	-809,205	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	CRNA CONTRACT EXPENSE	A	-58,905	ANESTHESIOLOGY	53.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A-8 | Date/Time Prepared: 2/25/2014 2:31 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	CRNA SALARY EXPENSE	A	-573,143	ANESTHESIOLOGY	53.00	0	33.02
33.03	CRNA FICA EXPENSE	A	-21,894	ANESTHESIOLOGY	53.00	0	33.03
33.04	CRNA BENEFIT EXPENSE	A	-144,661	EMPLOYEE BENEFITS	4.00	0	33.04
33.05	MARKETING SALARY EXPENSE	A	-10,156	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	MARKETING FICA EXPENSE	A	-733	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MARKETING BENEFIT EXPENSE	A	-2,563	EMPLOYEE BENEFITS	4.00	0	33.07
33.08	ADVERTISING EXPENSE	A	-14,695	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	MARKETING OTHER EXPENSE	A	4,544	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	LOBBYING EXPENSE	A	-18,333	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	MISCELLANEOUS INCOME	B	-17,431	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	PHYSICIAN RECRUITMENT EXPENSE	A	-925	EMPLOYEE BENEFITS	4.00	0	33.12
33.13			0		0.00	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,800,740				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A-8-1 | Date/Time Prepared: 2/25/2014 2:31 pm

	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 BLDG CAPITAL	8,768	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO MME CAPITAL	139,520	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HO INTEREST OPERATING	19,779	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HO MANAGEMENT OPERATING	2,356,592	2,297,162	4.00
4.01	4.00	EMPLOYEE BENEFITS	HEALTH INSURANCE	2,369,527	2,409,831	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	A&G PRINT SHOP - MMC	22,517	22,517	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	A&G PERSONNEL - ALMH	0	1,650	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	A&G PERSONNEL - VNA	0	1,225	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,916,703	4,732,385	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 HEALTH	100.00	6.00
7.00	B		0.00	MEMORIAL MD CTR	0.00	7.00
8.00	B		0.00	ABRAHAM LINCOLN	0.00	8.00
9.00	B		0.00	MEMORIAL VNA	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: 141339	Period: From 10/01/2012 To 09/30/2013	Worksheet A-8-1 Date/Time Prepared: 2/25/2014 2:31 pm

	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	8,768	9		1.00
2.00	139,520	9		2.00
3.00	19,779	0		3.00
4.00	59,430	0		4.00
4.01	-40,304	0		4.01
4.02	0	0		4.02
4.03	-1,650	0		4.03
4.04	-1,225	0		4.04
5.00	184,318			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	HOSPITAL		8.00
9.00	HOME HEALTH		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: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet A-8-2 | Date/Time Prepared: 2/25/2014 2:31 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	10,563	10,563	0	0	0	1.00
2.00	44.00	SKILLED NURSING FACILITY	5,720	5,720	0	0	0	2.00
3.00	50.00	OPERATING ROOM	5,200	5,200	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	218,233	218,233	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	22,500	22,500	0	0	0	5.00
6.00	60.00	LABORATORY	8,333	8,333	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	4,200	4,200	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	1,894	1,894	0	0	0	8.00
9.00	91.00	EMERGENCY	1,741,077	1,534,847	206,230	0	0	9.00
10.00	13.00	NURSING ADMINISTRATION	6,350	6,350	0	0	0	10.00
200.00			2,024,070	1,817,840	206,230		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	44.00	SKILLED NURSING FACILITY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	13.00	NURSING ADMINISTRATION	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	30.00	ADULTS & PEDIATRICS	0	0	0	10,563		1.00
2.00	44.00	SKILLED NURSING FACILITY	0	0	0	5,720		2.00
3.00	50.00	OPERATING ROOM	0	0	0	5,200		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	218,233		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	22,500		5.00
6.00	60.00	LABORATORY	0	0	0	8,333		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	4,200		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	1,894		8.00
9.00	91.00	EMERGENCY	0	0	0	1,534,847		9.00
10.00	13.00	NURSING ADMINISTRATION	0	0	0	6,350		10.00
200.00			0	0	0	1,817,840		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B Part I Date/Time Prepared: 2/25/2014 2:31 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,277,753	2,277,753				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,634,373		1,634,373			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,281,179	12,562	0	3,293,741		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,801,292	394,657	262,089	460,865	6,918,903	5.00
6.00	00600	MAINTENANCE & REPAIRS	-18,423	107,694	0	0	89,271	6.00
7.00	00700	OPERATION OF PLANT	1,747,263	616,497	47,701	184,369	2,595,830	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	157,605	12,478	2,615	22,882	195,580	8.00
9.00	00900	HOUSEKEEPING	455,395	45,537	667	91,247	592,846	9.00
10.00	01000	DIETARY	313,755	87,072	6,805	39,826	447,458	10.00
11.00	01100	CAFETERIA	417,565	33,461	0	76,218	527,244	11.00
13.00	01300	NURSING ADMINISTRATION	476,437	30,040	0	108,924	615,401	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	184,598	24,791	53,745	11,660	274,794	14.00
15.00	01500	PHARMACY	444,287	16,315	59,632	101,043	621,277	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	509,355	55,924	6,840	117,984	690,103	16.00
17.00	01700	SOCIAL SERVICE	40,419	4,141	0	9,587	54,147	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,131,939	202,411	28,306	487,518	2,850,174	30.00
44.00	04400	SKILLED NURSING FACILITY	816,658	111,434	17,705	190,169	1,135,966	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	864,376	124,258	153,326	153,816	1,295,776	50.00
53.00	05300	ANESTHESIOLOGY	39,264	11,869	47,950	0	99,083	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,934,158	93,568	766,007	264,034	3,057,767	54.00
60.00	06000	LABORATORY	2,096,705	43,848	35,998	222,586	2,399,137	60.00
65.00	06500	RESPIRATORY THERAPY	543,973	18,129	11,752	111,411	685,265	65.00
66.00	06600	PHYSICAL THERAPY	843,197	57,905	5,465	194,019	1,100,586	66.00
66.01	06601	PHYSICAL THERAPY SNF	322,467	0	0	0	322,467	66.01
68.00	06800	SPEECH PATHOLOGY	108,802	4,335	0	25,300	138,437	68.00
69.00	06900	ELECTROCARDIOLOGY	157,758	17,395	10,912	35,233	221,298	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	405,276	0	0	8,325	413,601	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	157,738	0	0	0	157,738	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	958,104	0	0	0	958,104	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,899,179	114,841	116,640	376,139	2,506,799	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)	31,002,447	2,241,162	1,634,155	3,293,155	30,965,052	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	8,975	0	0	8,975	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,073	27,616	218	586	32,493	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	31,006,520	2,277,753	1,634,373	3,293,741	31,006,520	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B Part I | Date/Time Prepared: 2/25/2014 2:31 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,918,903					5.00
6.00	00600	MAINTENANCE & REPAIRS	25,642	114,913				6.00
7.00	00700	OPERATION OF PLANT	745,624	84,128	3,425,582			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	56,178	2,223	37,289	291,270		8.00
9.00	00900	HOUSEKEEPING	170,288	240	136,078	8,301	907,753	9.00
10.00	01000	DIETARY	128,527	3,688	260,195	1,136	0	10.00
11.00	01100	CAFETERIA	151,445	0	99,989	2,038	8,105	11.00
13.00	01300	NURSING ADMINISTRATION	176,767	33	89,767	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,932	1,977	74,081	961	8,105	14.00
15.00	01500	PHARMACY	178,455	253	48,753	0	8,105	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	198,224	446	167,118	0	11,578	16.00
17.00	01700	SOCIAL SERVICE	15,553	0	12,374	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	818,681	8,433	604,860	119,630	303,358	30.00
44.00	04400	SKILLED NURSING FACILITY	326,294	3,481	332,994	98,109	119,258	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	372,197	1,531	371,318	18,117	115,785	50.00
53.00	05300	ANESTHESIOLOGY	28,461	386	35,468	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	878,311	1,052	279,606	8,884	74,102	54.00
60.00	06000	LABORATORY	689,126	2,310	131,029	728	23,157	60.00
65.00	06500	RESPIRATORY THERAPY	196,835	339	54,175	553	5,789	65.00
66.00	06600	PHYSICAL THERAPY	316,131	559	173,036	8,651	23,157	66.00
66.01	06601	PHYSICAL THERAPY SNF	92,625	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	39,765	13	12,954	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	63,565	366	51,981	0	5,789	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	118,802	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	45,309	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	275,205	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	720,050	3,455	343,175	21,408	184,098	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)	6,906,992	114,913	3,316,240	288,516	890,386	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,578	0	26,818	0	5,789	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,333	0	82,524	2,754	11,578	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,918,903	114,913	3,425,582	291,270	907,753	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B Part I | Date/Time Prepared: 2/25/2014 2:31 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	841,004					10.00
11.00	01100	CAFETERIA	0	788,821				11.00
13.00	01300	NURSING ADMINISTRATION	0	25,788	907,756			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,841	17,038	463,729		14.00
15.00	01500	PHARMACY	0	25,382	0	0	882,225	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	54,093	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,311	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	538,989	173,972	377,645	10,695	0	30.00
44.00	04400	SKILLED NURSING FACILITY	302,015	76,280	165,566	2,927	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	39,573	85,918	23,512	870	50.00
53.00	05300	ANESTHESIOLOGY	0	9,061	0	7,922	840	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	79,087	0	54,693	0	54.00
60.00	06000	LABORATORY	0	76,667	0	181,685	227	60.00
65.00	06500	RESPIRATORY THERAPY	0	36,746	0	1,322	52	65.00
66.00	06600	PHYSICAL THERAPY	0	52,680	0	829	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0	5,460	0	374	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,706	18,099	2,003	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	108,837	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	52,628	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	880,236	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	112,019	243,161	16,084	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)	841,004	788,666	907,427	463,511	882,225	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	155	329	218	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	841,004	788,821	907,756	463,729	882,225	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B Part I | Date/Time Prepared: 2/25/2014 2:31 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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	1,121,562					16.00
17.00	01700	SOCIAL SERVICE	0	85,385				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	239,653	68,253	6,114,343	0	6,114,343	30.00
44.00	04400	SKILLED NURSING FACILITY	35,113	17,132	2,615,135	0	2,615,135	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	70,907	0	2,395,504	0	2,395,504	50.00
53.00	05300	ANESTHESIOLOGY	0	0	181,221	0	181,221	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	205,222	0	4,638,724	0	4,638,724	54.00
60.00	06000	LABORATORY	68,521	0	3,572,587	0	3,572,587	60.00
65.00	06500	RESPIRATORY THERAPY	16,022	0	997,098	0	997,098	65.00
66.00	06600	PHYSICAL THERAPY	22,499	0	1,698,128	0	1,698,128	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	415,092	0	415,092	66.01
68.00	06800	SPEECH PATHOLOGY	341	0	197,344	0	197,344	68.00
69.00	06900	ELECTROCARDIOLOGY	13,636	0	387,443	0	387,443	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	641,240	0	641,240	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	255,675	0	255,675	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,113,545	0	2,113,545	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	444,875	0	4,595,124	0	4,595,124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,116,789	85,385	30,818,203	0	30,818,203	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	44,160	0	44,160	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,773	0	144,157	0	144,157	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,121,562	85,385	31,006,520	0	31,006,520	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B Part II | Date/Time Prepared: 2/25/2014 2:31 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,562	0	12,562	12,562	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	75,508	394,657	262,089	732,254	1,758	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	107,694	0	107,694	0	6.00
7.00	00700	OPERATION OF PLANT	0	616,497	47,701	664,198	703	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,478	2,615	15,093	87	8.00
9.00	00900	HOUSEKEEPING	0	45,537	667	46,204	348	9.00
10.00	01000	DIETARY	0	87,072	6,805	93,877	152	10.00
11.00	01100	CAFETERIA	0	33,461	0	33,461	291	11.00
13.00	01300	NURSING ADMINISTRATION	0	30,040	0	30,040	415	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	24,791	53,745	78,536	44	14.00
15.00	01500	PHARMACY	0	16,315	59,632	75,947	385	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	55,924	6,840	62,764	450	16.00
17.00	01700	SOCIAL SERVICE	0	4,141	0	4,141	37	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,990	202,411	28,306	234,707	1,859	30.00
44.00	04400	SKILLED NURSING FACILITY	0	111,434	17,705	129,139	725	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	124,258	153,326	277,584	587	50.00
53.00	05300	ANESTHESIOLOGY	0	11,869	47,950	59,819	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	111,816	93,568	766,007	971,391	1,007	54.00
60.00	06000	LABORATORY	0	43,848	35,998	79,846	849	60.00
65.00	06500	RESPIRATORY THERAPY	832	18,129	11,752	30,713	425	65.00
66.00	06600	PHYSICAL THERAPY	0	57,905	5,465	63,370	740	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0	4,335	0	4,335	97	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,395	10,912	28,307	134	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,128	0	0	2,128	32	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
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	114,841	116,640	231,481	1,435	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)	194,274	2,241,162	1,634,155	4,069,591	12,560	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	8,975	0	8,975	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	27,616	218	27,834	2	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	194,274	2,277,753	1,634,373	4,106,400	12,562	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B Part II | Date/Time Prepared: 2/25/2014 2:31 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	734,012					5.00
6.00	00600	MAINTENANCE & REPAIRS	2,720	95,158				6.00
7.00	00700	OPERATION OF PLANT	79,103	69,664	813,668			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,960	1,841	8,857	31,838		8.00
9.00	00900	HOUSEKEEPING	18,066	198	32,322	907	98,045	9.00
10.00	01000	DIETARY	13,635	3,054	61,803	124	0	10.00
11.00	01100	CAFETERIA	16,067	0	23,750	223	875	11.00
13.00	01300	NURSING ADMINISTRATION	18,753	28	21,322	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,374	1,637	17,596	105	875	14.00
15.00	01500	PHARMACY	18,932	209	11,580	0	875	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,030	369	39,695	0	1,251	16.00
17.00	01700	SOCIAL SERVICE	1,650	0	2,939	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	86,853	6,984	143,671	13,077	32,766	30.00
44.00	04400	SKILLED NURSING FACILITY	34,616	2,883	79,095	10,724	12,881	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	39,486	1,268	88,198	1,980	12,506	50.00
53.00	05300	ANESTHESIOLOGY	3,019	320	8,425	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,169	871	66,414	971	8,004	54.00
60.00	06000	LABORATORY	73,109	1,913	31,123	80	2,501	60.00
65.00	06500	RESPIRATORY THERAPY	20,882	281	12,868	60	625	65.00
66.00	06600	PHYSICAL THERAPY	33,538	463	41,101	946	2,501	66.00
66.01	06601	PHYSICAL THERAPY SNF	9,827	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	4,219	11	3,077	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,744	303	12,347	0	625	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,604	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	4,807	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,196	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	76,390	2,861	81,513	2,340	19,884	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)	732,749	95,158	787,696	31,537	96,169	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	273	0	6,370	0	625	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	990	0	19,602	301	1,251	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	15,256	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	734,012	110,414	813,668	31,838	98,045	202.00

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		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	172,645					10.00
11.00	01100	CAFETERIA	0	74,667				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,441	72,999			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	742	1,370	109,279		14.00
15.00	01500	PHARMACY	0	2,403	0	0	110,331	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,120	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	313	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	110,646	16,469	30,371	2,520	0	30.00
44.00	04400	SKILLED NURSING FACILITY	61,999	7,220	13,314	690	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,746	6,909	5,541	109	50.00
53.00	05300	ANESTHESIOLOGY	0	858	0	1,867	105	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,486	0	12,889	0	54.00
60.00	06000	LABORATORY	0	7,257	0	42,814	28	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,478	0	312	6	65.00
66.00	06600	PHYSICAL THERAPY	0	4,986	0	195	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0	517	0	88	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,013	1,455	472	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	25,648	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	12,402	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	110,083	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	10,603	19,554	3,790	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)	172,645	74,652	72,973	109,228	110,331	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15	26	51	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	172,645	74,667	72,999	109,279	110,331	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B Part II | Date/Time Prepared: 2/25/2014 2:31 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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	130,679					16.00
17.00	01700	SOCIAL SERVICE	0	9,080				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,923	7,258	715,104	0	715,104	30.00
44.00	04400	SKILLED NURSING FACILITY	4,091	1,822	359,199	0	359,199	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,262	0	446,176	0	446,176	50.00
53.00	05300	ANESTHESIOLOGY	0	0	74,413	0	74,413	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,911	0	1,186,113	0	1,186,113	54.00
60.00	06000	LABORATORY	7,984	0	247,504	0	247,504	60.00
65.00	06500	RESPIRATORY THERAPY	1,867	0	71,517	0	71,517	65.00
66.00	06600	PHYSICAL THERAPY	2,622	0	150,462	0	150,462	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	9,827	0	9,827	66.01
68.00	06800	SPEECH PATHOLOGY	40	0	12,384	0	12,384	68.00
69.00	06900	ELECTROCARDIOLOGY	1,589	0	52,989	0	52,989	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	40,412	0	40,412	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	17,209	0	17,209	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	139,279	0	139,279	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	51,834	0	501,685	0	501,685	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)	130,123	9,080	4,024,273	0	4,024,273	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	16,243	0	16,243	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	556	0	50,628	0	50,628	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	15,256	0	15,256	201.00
202.00		TOTAL (sum lines 118-201)	130,679	9,080	4,106,400	0	4,106,400	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B-1 | Date/Time Prepared: 2/25/2014 2:31 pm

		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	164,464					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,622,085				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	907	0	12,885,045			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,496	260,119	1,802,896	-6,918,903	24,087,617	5.00
6.00	00600	MAINTENANCE & REPAIRS	7,776	0	0	0	89,271	6.00
7.00	00700	OPERATION OF PLANT	44,514	47,342	721,246	0	2,595,830	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	901	2,595	89,513	0	195,580	8.00
9.00	00900	HOUSEKEEPING	3,288	662	356,958	0	592,846	9.00
10.00	01000	DIETARY	6,287	6,754	155,799	0	447,458	10.00
11.00	01100	CAFETERIA	2,416	0	298,162	0	527,244	11.00
13.00	01300	NURSING ADMINISTRATION	2,169	0	426,109	0	615,401	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,790	53,341	45,614	0	274,794	14.00
15.00	01500	PHARMACY	1,178	59,184	395,280	0	621,277	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,038	6,789	461,552	0	690,103	16.00
17.00	01700	SOCIAL SERVICE	299	0	37,505	0	54,147	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,615	28,093	1,907,146	0	2,850,174	30.00
44.00	04400	SKILLED NURSING FACILITY	8,046	17,572	743,938	0	1,135,966	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,972	152,173	601,726	0	1,295,776	50.00
53.00	05300	ANESTHESIOLOGY	857	47,590	0	0	99,083	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,756	760,247	1,032,895	0	3,057,767	54.00
60.00	06000	LABORATORY	3,166	35,727	870,753	0	2,399,137	60.00
65.00	06500	RESPIRATORY THERAPY	1,309	11,664	435,839	0	685,265	65.00
66.00	06600	PHYSICAL THERAPY	4,181	5,424	758,997	0	1,100,586	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	322,467	66.01
68.00	06800	SPEECH PATHOLOGY	313	0	98,975	0	138,437	68.00
69.00	06900	ELECTROCARDIOLOGY	1,256	10,830	137,832	0	221,298	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	32,569	0	413,601	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	157,738	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	958,104	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,292	115,763	1,471,447	0	2,506,799	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)	161,822	1,621,869	12,882,751	-6,918,903	24,046,149	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	648	0	0	0	8,975	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,994	216	2,294	0	32,493	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,277,753	1,634,373	3,293,741		6,918,903	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.849554	1.007575	0.255625		0.287239	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,562		734,012	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000975		0.030473	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B-1 | Date/Time Prepared: 2/25/2014 2:31 pm

		Cost Center Description	MAINTENANCE & REPAIRS (HOURS OF SERVICE)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	17,264					6.00
7.00	00700	OPERATION OF PLANT	12,639	82,771				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	334	901	316,356			8.00
9.00	00900	HOUSEKEEPING	36	3,288	9,016	4,704		9.00
10.00	01000	DIETARY	554	6,287	1,234	0	32,611	10.00
11.00	01100	CAFETERIA	0	2,416	2,214	42	0	11.00
13.00	01300	NURSING ADMINISTRATION	5	2,169	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	297	1,790	1,044	42	0	14.00
15.00	01500	PHARMACY	38	1,178	0	42	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	67	4,038	0	60	0	16.00
17.00	01700	SOCIAL SERVICE	0	299	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,267	14,615	129,932	1,572	20,900	30.00
44.00	04400	SKILLED NURSING FACILITY	523	8,046	106,559	618	11,711	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	230	8,972	19,677	600	0	50.00
53.00	05300	ANESTHESIOLOGY	58	857	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	158	6,756	9,649	384	0	54.00
60.00	06000	LABORATORY	347	3,166	791	120	0	60.00
65.00	06500	RESPIRATORY THERAPY	51	1,309	601	30	0	65.00
66.00	06600	PHYSICAL THERAPY	84	4,181	9,396	120	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	2	313	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	55	1,256	0	30	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
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	519	8,292	23,252	954	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)	17,264	80,129	313,365	4,614	32,611	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	648	0	30	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,994	2,991	60	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	114,913	3,425,582	291,270	907,753	841,004	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.656221	41.386258	0.920703	192.974702	25.788967	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	110,414	813,668	31,838	98,045	172,645	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.511932	9.830351	0.100640	20.842900	5.294073	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B-1 | Date/Time Prepared: 2/25/2014 2:31 pm

		Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	40,744					11.00
13.00	01300	NURSING ADMINISTRATION	1,332	201,123				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	405	3,775	1,389,886			14.00
15.00	01500	PHARMACY	1,311	0	0	958,104		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,794	0	0	0	3,290	16.00
17.00	01700	SOCIAL SERVICE	171	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,986	83,671	32,055	0	703	30.00
44.00	04400	SKILLED NURSING FACILITY	3,940	36,683	8,772	0	103	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,044	19,036	70,470	945	208	50.00
53.00	05300	ANESTHESIOLOGY	468	0	23,744	912	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,085	0	163,926	0	602	54.00
60.00	06000	LABORATORY	3,960	0	544,544	246	201	60.00
65.00	06500	RESPIRATORY THERAPY	1,898	0	3,963	56	47	65.00
66.00	06600	PHYSICAL THERAPY	2,721	0	2,484	0	66	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	282	0	1,121	0	1	68.00
69.00	06900	ELECTROCARDIOLOGY	553	4,010	6,003	0	40	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	326,205	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	157,738	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	955,945	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,786	53,875	48,207	0	1,305	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)	40,736	201,050	1,389,232	958,104	3,276	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8	73	654	0	14	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	788,821	907,756	463,729	882,225	1,121,562	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.360421	4.513437	0.333645	0.920803	340.900304	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	74,667	72,999	109,279	110,331	130,679	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.832589	0.362957	0.078624	0.115156	39.720061	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet B-1 | Date/Time Prepared: 2/25/2014 2:31 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)		
			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
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
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	2,183		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	1,745		30.00
44.00	04400	SKILLED NURSING FACILITY	438		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
66.01	06601	PHYSICAL THERAPY SNF	0		66.01
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	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)	2,183		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0		194.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	85,385		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	39.113605		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,080		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.159414		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet C Part I Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,114,343		6,114,343	0	6,114,343	30.00
44.00	04400	SKILLED NURSING FACILITY	2,615,135		2,615,135	0	2,615,135	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,395,504		2,395,504	0	2,395,504	50.00
53.00	05300	ANESTHESIOLOGY	181,221		181,221	0	181,221	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,638,724		4,638,724	0	4,638,724	54.00
60.00	06000	LABORATORY	3,572,587		3,572,587	0	3,572,587	60.00
65.00	06500	RESPIRATORY THERAPY	997,098	0	997,098	0	997,098	65.00
66.00	06600	PHYSICAL THERAPY	1,698,128	0	1,698,128	0	1,698,128	66.00
66.01	06601	PHYSICAL THERAPY SNF	415,092	0	415,092	0	415,092	66.01
68.00	06800	SPEECH PATHOLOGY	197,344	0	197,344	0	197,344	68.00
69.00	06900	ELECTROCARDIOLOGY	387,443		387,443	0	387,443	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	641,240		641,240	0	641,240	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	255,675		255,675	0	255,675	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,113,545		2,113,545	0	2,113,545	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,595,124		4,595,124	0	4,595,124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	308,542		308,542		308,542	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	31,126,745	0	31,126,745	0	31,126,745	200.00
201.00		Less Observation Beds	308,542		308,542		308,542	201.00
202.00		Total (see instructions)	30,818,203	0	30,818,203	0	30,818,203	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet C Part I Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,068,628		6,068,628			30.00
44.00	04400	SKILLED NURSING FACILITY	996,852		996,852			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	420,154	5,533,183	5,953,337	0.402380	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	85,313	429,673	514,986	0.351895	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,629,621	26,083,820	28,713,441	0.161552	0.000000	54.00
60.00	06000	LABORATORY	2,148,533	9,280,763	11,429,296	0.312582	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	295,673	1,475,726	1,771,399	0.562887	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	878,799	2,583,346	3,462,145	0.490484	0.000000	66.00
66.01	06601	PHYSICAL THERAPY SNF	1,164,493	0	1,164,493	0.356457	0.000000	66.01
68.00	06800	SPEECH PATHOLOGY	83,328	344,028	427,356	0.461779	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	367,161	1,548,077	1,915,238	0.202295	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,540,370	1,842,730	4,383,100	0.146298	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	138,619	785,925	924,544	0.276542	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,310,438	1,491,188	2,801,626	0.754399	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	110,934	5,009,081	5,120,015	0.897483	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,580	319,854	325,434	0.948094	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	19,244,496	56,727,394	75,971,890			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	19,244,496	56,727,394	75,971,890			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet C Part I Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
66.01	06601	PHYSICAL THERAPY SNF	0.000000		66.01
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
		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: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D Part II Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	446,176	5,953,337	0.074946	120,679	9,044	50.00
53.00	05300	ANESTHESIOLOGY	74,413	514,986	0.144495	43,922	6,347	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,186,113	28,713,441	0.041309	1,950,450	80,571	54.00
60.00	06000	LABORATORY	247,504	11,429,296	0.021655	1,667,839	36,117	60.00
65.00	06500	RESPIRATORY THERAPY	71,517	1,771,399	0.040373	188,698	7,618	65.00
66.00	06600	PHYSICAL THERAPY	150,462	3,462,145	0.043459	175,351	7,621	66.00
66.01	06601	PHYSICAL THERAPY SNF	9,827	1,164,493	0.008439	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	12,384	427,356	0.028978	61,677	1,787	68.00
69.00	06900	ELECTROCARDIOLOGY	52,989	1,915,238	0.027667	261,360	7,231	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,412	4,383,100	0.009220	1,333,891	12,298	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	17,209	924,544	0.018614	54,794	1,020	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	139,279	2,801,626	0.049714	703,354	34,967	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	501,685	5,120,015	0.097985	1,420	139	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	325,434	0.000000	5,580	0	92.00
200.00		Total (lines 50-199)	2,949,970	68,906,410		6,569,015	204,760	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D Part IV | Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
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
		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: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D Part IV | Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,953,337	0.000000	0.000000	120,679	50.00
53.00	05300	ANESTHESIOLOGY	0	514,986	0.000000	0.000000	43,922	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,713,441	0.000000	0.000000	1,950,450	54.00
60.00	06000	LABORATORY	0	11,429,296	0.000000	0.000000	1,667,839	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,771,399	0.000000	0.000000	188,698	65.00
66.00	06600	PHYSICAL THERAPY	0	3,462,145	0.000000	0.000000	175,351	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	1,164,493	0.000000	0.000000	0	66.01
68.00	06800	SPEECH PATHOLOGY	0	427,356	0.000000	0.000000	61,677	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,915,238	0.000000	0.000000	261,360	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,383,100	0.000000	0.000000	1,333,891	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	924,544	0.000000	0.000000	54,794	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,801,626	0.000000	0.000000	703,354	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	5,120,015	0.000000	0.000000	1,420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	325,434	0.000000	0.000000	5,580	92.00
200.00		Total (lines 50-199)	0	68,906,410			6,569,015	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D Part IV | Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0		66.01
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
		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: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D Part V Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.402380	0	2,525,199	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.351895	0	200,837	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161552	0	10,105,315	0	0	54.00
60.00	06000	LABORATORY	0.312582	0	3,519,175	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.562887	0	656,549	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.490484	0	939,912	0	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0.356457	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0.461779	0	50,745	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.202295	0	731,039	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.146298	0	755,101	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.276542	0	585,611	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.754399	0	779,868	1,915	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.897483	0	1,550,392	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.948094	0	114,510	0	0	92.00
200.00		Subtotal (see instructions)		0	22,514,253	1,915	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	22,514,253	1,915	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D Part V Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,016,090	0		50.00
53.00	05300	ANESTHESIOLOGY	70,674	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,632,534	0		54.00
60.00	06000	LABORATORY	1,100,031	0		60.00
65.00	06500	RESPIRATORY THERAPY	369,563	0		65.00
66.00	06600	PHYSICAL THERAPY	461,012	0		66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0		66.01
68.00	06800	SPEECH PATHOLOGY	23,433	0		68.00
69.00	06900	ELECTROCARDIOLOGY	147,886	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	110,470	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	161,946	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	588,332	1,445		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,391,450	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	108,566	0		92.00
200.00		Subtotal (see instructions)	7,181,987	1,445		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	7,181,987	1,445		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141339 | Component CCN: 14Z339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D Part V Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.402380	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.351895	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161552	0	0	0	0	54.00
60.00	06000	LABORATORY	0.312582	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.562887	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.490484	0	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0.356457	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0.461779	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.202295	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.146298	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.276542	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.754399	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.897483	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.948094	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: 141339 | Component CCN: 14Z339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D Part V | Date/Time Prepared: 2/25/2014 2:31 pm

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
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
66.01	06601	PHYSICAL THERAPY SNF	0	0		66.01
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
		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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141339 | Component CCN: 145539 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D Part IV | Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
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
		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: 141339 | Component CCN: 145539 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D Part IV | Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,953,337	0.000000	0.000000	8,843	50.00
53.00	05300	ANESTHESIOLOGY	0	514,986	0.000000	0.000000	2,727	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,713,441	0.000000	0.000000	152,922	54.00
60.00	06000	LABORATORY	0	11,429,296	0.000000	0.000000	276,967	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,771,399	0.000000	0.000000	3,603	65.00
66.00	06600	PHYSICAL THERAPY	0	3,462,145	0.000000	0.000000	299,265	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	1,164,493	0.000000	0.000000	1,111,978	66.01
68.00	06800	SPEECH PATHOLOGY	0	427,356	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,915,238	0.000000	0.000000	10,408	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,383,100	0.000000	0.000000	387,304	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	924,544	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,801,626	0.000000	0.000000	231,663	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	5,120,015	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	325,434	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	68,906,410			2,485,680	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141339 | Component CCN: 145539 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D Part IV | Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0		66.01
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
		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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D-1 | Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,410	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,043	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,770	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	124	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)	243	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,344	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)	58	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)	172	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)	6,114,343	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)	414,780	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,699,563	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)	5,699,563	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)	1,130.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,779,355	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)	3,779,355	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D-1 | Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,921,499	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,700,854	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)	65,551	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	194,393	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	259,944	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)	273	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,130.19	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	308,542	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D-1 | Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Hospital | Cost

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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141339 Component CCN: 145539	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1 Date/Time Prepared: 2/25/2014 2:31 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,183	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,183	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,183	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,676	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,615,135	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,615,135	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)	2,615,135	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D-1

Component CCN: 145539 | Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	2,615,135	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	625.18	71.00
72.00	Program routine service cost (line 9 x line 71)	1,672,982	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,672,982	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,672,982	83.00
84.00	Program inpatient ancillary services (see instructions)	894,516	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,567,498	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D-1

Component CCN: 145539 | Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Skilled Nursing Facility | PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D-3 | Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,070,066		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.402380	120,679	48,559	50.00
53.00	05300	ANESTHESIOLOGY	0.351895	43,922	15,456	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161552	1,950,450	315,099	54.00
60.00	06000	LABORATORY	0.312582	1,667,839	521,336	60.00
65.00	06500	RESPIRATORY THERAPY	0.562887	188,698	106,216	65.00
66.00	06600	PHYSICAL THERAPY	0.490484	175,351	86,007	66.00
66.01	06601	PHYSICAL THERAPY SNF	0.356457	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0.461779	61,677	28,481	68.00
69.00	06900	ELECTROCARDIOLOGY	0.202295	261,360	52,872	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.146298	1,333,891	195,146	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.276542	54,794	15,153	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.754399	703,354	530,610	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.897483	1,420	1,274	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.948094	5,580	5,290	92.00
200.00		Total (sum of lines 50-94 and 96-98)		6,569,015	1,921,499	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)		6,569,015		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D-3

Component CCN: 14Z339 | Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.402380	1,254	505	50.00
53.00	05300	ANESTHESIOLOGY	0.351895	966	340	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161552	12,286	1,985	54.00
60.00	06000	LABORATORY	0.312582	36,866	11,524	60.00
65.00	06500	RESPIRATORY THERAPY	0.562887	5,940	3,344	65.00
66.00	06600	PHYSICAL THERAPY	0.490484	14,960	7,338	66.00
66.01	06601	PHYSICAL THERAPY SNF	0.356457	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0.461779	2,069	955	68.00
69.00	06900	ELECTROCARDIOLOGY	0.202295	2,163	438	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.146298	69,878	10,223	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.276542	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.754399	45,086	34,013	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.897483	33	30	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.948094	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		191,501	70,695	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)		191,501		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet D-3

Component CCN: 145539 | Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.402380	8,843	3,558	50.00
53.00	05300	ANESTHESIOLOGY	0.351895	2,727	960	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161552	152,922	24,705	54.00
60.00	06000	LABORATORY	0.312582	276,967	86,575	60.00
65.00	06500	RESPIRATORY THERAPY	0.562887	3,603	2,028	65.00
66.00	06600	PHYSICAL THERAPY	0.490484	299,265	146,785	66.00
66.01	06601	PHYSICAL THERAPY SNF	0.356457	1,111,978	396,372	66.01
68.00	06800	SPEECH PATHOLOGY	0.461779	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.202295	10,408	2,105	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.146298	387,304	56,662	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.276542	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.754399	231,663	174,766	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.897483	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.948094	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,485,680	894,516	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)		2,485,680		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141339	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part B Date/Time Prepared: 2/25/2014 2:31 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,183,432	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)	7,183,432	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)	7,255,266	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)	57,051	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,770,929	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)	3,427,286	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)	3,427,286	30.00
31.00	Primary payer payments	842	31.00
32.00	Subtotal (line 30 minus line 31)	3,426,444	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)	848,808	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	746,951	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	796,634	36.00
37.00	Subtotal (see instructions)	4,173,395	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)	4,173,395	40.00
40.01	Sequestration adjustment (see instructions)	41,734	40.01
41.00	Interim payments	4,134,310	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-2,649	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: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,768,172		4,658,747	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	04/15/2013	143,296		0	3.01
3.02		09/23/2013	74,080		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	04/15/2013	374,884	3.50
3.51			0	09/23/2013	149,553	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		217,376		-524,437	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,985,548		4,134,310	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		181,018		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		2,649	6.02
7.00	Total Medicare program liability (see instructions)		5,166,566		4,131,661	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: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 2/25/2014 2:31 pm

Component CCN: 14Z339 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		299,692		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	04/15/2013	18,928		0	3.01
3.02		09/23/2013	8,510		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		27,438		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)		327,130		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		1,583		0	6.02
7.00	Total Medicare program liability (see instructions)		325,547		0	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: 141339 | Component CCN: 145539 | Period: From 10/01/2012 To 09/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		986,551		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		986,551		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		1,032		0	6.02
7.00	Total Medicare program liability (see instructions)		985,519		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: 141339	Period: From 10/01/2012 To 09/30/2013	Worksheet E-1 Part II Date/Time Prepared: 2/25/2014 2:31 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	1,362	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	3,344	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	164	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	4,770	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	75,971,890	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	3,670,968	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: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet E-2

Component CCN: 14Z339 | Date/Time Prepared: 2/25/2014 2:31 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	262,543	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)	71,402	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	230	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)	333,945	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	333,945	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)	333,945	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,110	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)	328,835	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)	328,835	0	19.00
19.01	Sequestration adjustment (see instructions)	3,288	0	19.01
20.00	Interim payments	327,130	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	-1,583	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: 141339	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part V Date/Time Prepared: 2/25/2014 2:31 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	5,700,854	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)	5,700,854	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,757,863	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)	5,757,863	19.00
20.00	Deductibles (exclude professional component)	640,815	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	5,117,048	22.00
23.00	Coinsurance	5,314	23.00
24.00	Subtotal (line 22 minus line 23)	5,111,734	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	121,614	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	107,020	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	115,029	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,218,754	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)	5,218,754	30.00
30.01	Sequestration adjustment (see instructions)	52,188	30.01
31.00	Interim payments	4,985,548	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	181,018	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141339 Component CCN: 145539	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part VI Date/Time Prepared: 2/25/2014 2:31 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,092,975	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,092,975	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	97,501	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	995,474	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	995,474	15.00
15.01	Sequestration adjustment (see instructions)	9,955	15.01
16.00	Interim payments	986,551	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17	-1,032	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet G | Date/Time Prepared: 2/25/2014 2:31 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	8,658,944	0	0	0	1.00
2.00	Temporary investments	1,503,538	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,266,314	0	0	0	4.00
5.00	Other receivable	926,861	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,533,637	0	0	0	6.00
7.00	Inventory	679,048	0	0	0	7.00
8.00	Prepaid expenses	348,592	0	0	0	8.00
9.00	Other current assets	487,763	0	0	0	9.00
10.00	Due from other funds	295,689	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	18,633,112	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	737,345	0	0	0	12.00
13.00	Land improvements	3,227,898	0	0	0	13.00
14.00	Accumulated depreciation	-1,091,197	0	0	0	14.00
15.00	Buildings	24,691,679	0	0	0	15.00
16.00	Accumulated depreciation	-6,823,031	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	20,046,595	0	0	0	23.00
24.00	Accumulated depreciation	-16,479,974	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	2,110,095	0	0	0	27.00
28.00	Accumulated depreciation	-231,274	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	26,188,136	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,826,311	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	318,183	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,144,494	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	47,965,742	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	633,096	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,821,956	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	568,394	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	37,711	0	0	0	43.00
44.00	Other current liabilities	1,190,605	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,251,762	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	18,081,004	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	446,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	18,527,004	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	22,778,766	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	25,186,976				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)	25,186,976	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	47,965,742	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet G-1 | Date/Time Prepared: 2/25/2014 2:31 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		22,577,102		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,801,710				2.00
3.00	Total (sum of line 1 and line 2)		25,378,812		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)		25,378,812		0		11.00
12.00	RELEASED FROM RESTRICTION	191,836		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		191,836		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		25,186,976		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	RELEASED FROM RESTRICTION		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: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/25/2014 2:31 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,571,318		5,571,318	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	139,959		139,959	5.00
6.00	Swing bed - NF	294,727		294,727	6.00
7.00	SKILLED NURSING FACILITY	879,847		879,847	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)	6,885,851		6,885,851	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)	6,885,851		6,885,851	17.00
18.00	Ancillary services	12,226,965	52,671,566	64,898,531	18.00
19.00	Outpatient services	121,372	5,391,495	5,512,867	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL CHARGES	459,376	8,702,143	9,161,519	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	19,693,564	66,765,204	86,458,768	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		34,807,260		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		34,807,260		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141339 | Period: From 10/01/2012 To 09/30/2013 | Worksheet G-3 | Date/Time Prepared: 2/25/2014 2:31 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	86,458,768	1.00
2.00	Less contractual allowances and discounts on patients' accounts	52,813,491	2.00
3.00	Net patient revenues (line 1 minus line 2)	33,645,277	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	34,807,260	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,161,983	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	616,755	6.00
7.00	Income from investments	99,287	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	1,833	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	182,885	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	11,211	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	HOSPITAL ACCESS IMPROVEMENT	2,395,861	24.00
24.01	SALE OF REFUSE AND JUNK	5,997	24.01
24.02	MISCELLANEOUS INCOME	52,560	24.02
24.03	GAIN ON DISPOSAL OF ASSETS	25,057	24.03
24.04	UNREALIZED GAINS ON INVESTMENTS	211,465	24.04
24.05	MEANINGFUL USE INCOME	360,782	24.05
25.00	Total other income (sum of lines 6-24)	3,963,693	25.00
26.00	Total (line 5 plus line 25)	2,801,710	26.00
27.00	OTHER	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,801,710	29.00