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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141322	Period: From 10/01/2013 To 09/30/2014	Worksheet S Parts I-III Date/Time Prepared: 2/20/2015 10:43 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/20/2015 Time: 10:43 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ABRAHAM LINCOLN MEMORIAL HOSPITAL (141322) for the cost reporting period beginning 10/01/2013 and ending 09/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	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	137,210	5,019	475,286	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	261,550	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	398,760	5,019	475,286	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 2/20/2015 9:54 am

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

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

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2013	09/30/2014	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)			22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0		23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/20/2015 9:54 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)			39.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/20/2015 9:54 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings		
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/20/2015 9:54 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141322	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part I Date/Time Prepared: 2/20/2015 9:54 am

		V	XIX	
		1.00	2.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	119,029	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/20/2015 9:54 am

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H058	140.00

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

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

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

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

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	613,130	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)	10/01/2013	09/30/2014	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 2/20/2015 9:54 am

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	12/05/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 2/20/2015 9:54 am

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 2/20/2015 9:54 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	12/05/2014			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.		MANAGING DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 2/20/2015 9:54 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	97,293.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	97,293.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	97,293.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 2/20/2015 9:54 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,876	496	3,503			1.00
2.00	HMO and other (see instructions)	120	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	623	0	735			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	17			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,499	496	4,255			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		278	446			13.00
14.00	Total (see instructions)	2,499	774	4,701	0.00	226.98	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	226.98	27.00
28.00	Observation Bed Days		18	146			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			63			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	45			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 2/20/2015 9:54 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	521	191	1,092	1.00
2.00	HMO and other (see instructions)			32	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	521	191	1,092	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-10 | Date/Time Prepared: 2/20/2015 9:54 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.376277	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,807,792	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	2,336,050	5.00
6.00	Medicaid charges	16,557,018	6.00
7.00	Medicaid cost (line 1 times line 6)	6,230,025	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,086,183	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	20,812	9.00
10.00	Stand-alone SCHIP charges	117,219	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	44,107	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	23,295	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,109,478	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,787,131	1,408,144	3,195,275	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	672,456	529,852	1,202,308	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	672,456	529,852	1,202,308	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,829,301	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	843,820	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	985,481	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	370,814	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,573,122	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,682,600	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A | Date/Time Prepared: 2/20/2015 9:54 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,075,294	3,075,294	2,344,110	5,419,404	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,497,694	1,497,694	78,057	1,575,751	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	132,308	4,185,068	4,317,376	0	4,317,376	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,623,634	5,053,504	6,677,138	-15,105	6,662,033	5.00
7.00	00700	OPERATION OF PLANT	453,444	640,439	1,093,883	0	1,093,883	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	178,265	178,265	8.00
9.00	00900	HOUSEKEEPING	383,447	218,685	602,132	-178,265	423,867	9.00
10.00	01000	DIETARY	491,731	337,654	829,385	-532,905	296,480	10.00
11.00	01100	CAFETERIA	0	0	0	530,108	530,108	11.00
13.00	01300	NURSING ADMINISTRATION	303,530	14,877	318,407	-7,904	310,503	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	255,310	281,944	537,254	-199,759	337,495	14.00
15.00	01500	PHARMACY	437,220	1,197,000	1,634,220	-1,167,011	467,209	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	402,430	115,917	518,347	0	518,347	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	36,450	36,450	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,450,565	275,031	1,725,596	731,958	2,457,554	30.00
43.00	04300	NURSERY	0	0	0	107,583	107,583	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	851,236	948,711	1,799,947	-369,110	1,430,837	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	759,101	177,805	936,906	-839,541	97,365	52.00
53.00	05300	ANESTHESIOLOGY	779,928	356,356	1,136,284	0	1,136,284	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,211,006	629,866	1,840,872	-39,791	1,801,081	54.00
60.00	06000	LABORATORY	796,707	1,006,023	1,802,730	0	1,802,730	60.00
65.00	06500	RESPIRATORY THERAPY	353,596	78,635	432,231	0	432,231	65.00
66.00	06600	PHYSICAL THERAPY	1,285,888	58,635	1,344,523	0	1,344,523	66.00
68.00	06800	SPEECH PATHOLOGY	81,589	0	81,589	0	81,589	68.00
69.00	06900	ELECTROCARDIOLOGY	56,349	89,251	145,600	0	145,600	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	169,238	169,238	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	399,640	399,640	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,217,494	1,217,494	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	120,226	18,374	138,600	0	138,600	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,263,041	2,243,847	3,506,888	-36,450	3,470,438	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		2,407,062	2,407,062	-2,407,062	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,492,286	24,907,672	38,399,958	0	38,399,958	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	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118-199)	13,492,286	24,907,672	38,399,958	0	38,399,958	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A | Date/Time Prepared: 2/20/2015 9:54 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-317,116	5,102,288		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-72,777	1,502,974		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-90,510	4,226,866		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,441,946	5,220,087		5.00
7.00	00700	OPERATION OF PLANT	0	1,093,883		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	178,265		8.00
9.00	00900	HOUSEKEEPING	0	423,867		9.00
10.00	01000	DIETARY	0	296,480		10.00
11.00	01100	CAFETERIA	-126,783	403,325		11.00
13.00	01300	NURSING ADMINISTRATION	0	310,503		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	337,495		14.00
15.00	01500	PHARMACY	0	467,209		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,999	516,348		16.00
17.00	01700	SOCIAL SERVICE	0	36,450		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,457,554		30.00
43.00	04300	NURSERY	0	107,583		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-700	1,430,137		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-54	97,311		52.00
53.00	05300	ANESTHESIOLOGY	-779,928	356,356		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,801,081		54.00
60.00	06000	LABORATORY	-20,478	1,782,252		60.00
65.00	06500	RESPIRATORY THERAPY	-1,305	430,926		65.00
66.00	06600	PHYSICAL THERAPY	-52,546	1,291,977		66.00
68.00	06800	SPEECH PATHOLOGY	-500	81,089		68.00
69.00	06900	ELECTROCARDIOLOGY	0	145,600		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	169,238		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	399,640		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,217,494		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	138,600		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,762,469	1,707,969		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,669,111	33,730,847		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
200.00		TOTAL (SUM OF LINES 118-199)	-4,669,111	33,730,847		200.00

RECLASSIFICATIONS | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/20/2015 9:54 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS STERILE PROCESSING SALARIES				
1.00	OPERATING ROOM	50.00	62,226	0	1.00
	TOTALS		62,226	0	
	B - RECLASS LABOR & DELIVERY EXPENSES				
1.00	NURSERY	43.00	87,166	20,417	1.00
2.00	ADULTS & PEDIATRICS	30.00	593,048	138,910	2.00
	TOTALS		680,214	159,327	
	C - RECLASS SOCIAL SERVICE FEES				
1.00	SOCIAL SERVICE	17.00	0	36,450	1.00
	TOTALS		0	36,450	
	D - RECLASS PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	15,105	1.00
	TOTALS		0	15,105	
	E - RECLASS DRUG EXPENSE				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,217,494	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	1,217,494	
	F - RECLASS LAUNDRY EXPENSE				
1.00	LAUNDRY & LINEN SERVICE	8.00	37,411	140,854	1.00
	TOTALS		37,411	140,854	
	G - RECLASS MEDICAL SUPPLIES EXPENSE				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	169,238	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	399,640	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	568,878	
	H - RECLASS CAFETERIA EXPENSE				
1.00	CAFETERIA	11.00	315,357	214,751	1.00
	TOTALS		315,357	214,751	
	I - RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,202,757	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	70,235	2.00
	TOTALS		0	2,272,992	
	J - RECLASS BOND AMORTIZATION EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	129,927	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,143	2.00
	TOTALS		0	134,070	
500.00	Grand Total: Increases		1,095,208	4,759,921	500.00

RECLASSIFICATIONS | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/20/2015 9:54 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS STERILE PROCESSING SALARIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	62,226	0	0		1.00
	TOTALS		62,226	0			
	B - RECLASS LABOR & DELIVERY EXPENSES						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	680,214	159,327	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		680,214	159,327			
	C - RECLASS SOCIAL SERVICE FEES						
1.00	EMERGENCY	91.00	0	36,450	0		1.00
	TOTALS		0	36,450			
	D - RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,105	0		1.00
	TOTALS		0	15,105			
	E - RECLASS DRUG EXPENSE						
1.00	DIETARY	10.00	0	2,797	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	7,904	0		2.00
3.00	PHARMACY	15.00	0	1,166,966	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	39,791	0		4.00
5.00	OPERATING ROOM	50.00	0	36	0		5.00
	TOTALS		0	1,217,494			
	F - RECLASS LAUNDRY EXPENSE						
1.00	HOUSEKEEPING	9.00	37,411	140,854	0		1.00
	TOTALS		37,411	140,854			
	G - RECLASS MEDICAL SUPPLIES EXPENSE						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	137,533	0		1.00
2.00	PHARMACY	15.00	0	45	0		2.00
3.00	OPERATING ROOM	50.00	0	431,300	0		3.00
	TOTALS		0	568,878			
	H - RECLASS CAFETERIA EXPENSE						
1.00	DIETARY	10.00	315,357	214,751	0		1.00
	TOTALS		315,357	214,751			
	I - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	2,272,992	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	2,272,992			
	J - RECLASS BOND AMORTIZATION EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	134,070	14		1.00
2.00		0.00	0	0	14		2.00
	TOTALS		0	134,070			
500.00	Grand Total: Decreases		1,095,208	4,759,921			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 2/20/2015 9:54 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	834,848	0	0	0	0	1.00
2.00	Land Improvements	5,784,294	192,550	0	192,550	0	2.00
3.00	Buildings and Fixtures	41,444,101	645,209	0	645,209	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	12,624,207	647,721	0	647,721	50,082	6.00
7.00	HIT designated Assets	1,912,947	613,130	0	613,130	0	7.00
8.00	Subtotal (sum of lines 1-7)	62,600,397	2,098,610	0	2,098,610	50,082	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	62,600,397	2,098,610	0	2,098,610	50,082	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	834,848	0	1.00
2.00	Land Improvements	5,976,844	0	2.00
3.00	Buildings and Fixtures	42,089,310	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	13,221,846	0	6.00
7.00	HIT designated Assets	2,526,077	0	7.00
8.00	Subtotal (sum of lines 1-7)	64,648,925	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	64,648,925	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 2/20/2015 9:54 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,075,294	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,497,694	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,572,988	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3,075,294	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,497,694	2.00
3.00	Total (sum of lines 1-2)	0	4,572,988	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part III Date/Time Prepared: 2/20/2015 9:54 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	48,901,002	0	48,901,002	0.756409	11,426	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,747,923	0	15,747,923	0.243591	3,679	2.00
3.00	Total (sum of lines 1-2)	64,648,925	0	64,648,925	1.000000	15,105	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	11,426	3,083,087	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	3,679	1,435,277	0	2.00
3.00	Total (sum of lines 1-2)	0	0	15,105	4,518,364	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,877,848	11,426	0	129,927	5,102,288	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	59,875	3,679	0	4,143	1,502,974	2.00
3.00	Total (sum of lines 1-2)	1,937,723	15,105	0	134,070	6,605,262	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/20/2015 9:54 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-324,909	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-10,360	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-2,953	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,782,093			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-268,111			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-126,783	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,999	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	-226,575	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	LABOR & DELIVERY MISCELLANEOUS REV	B	-54	DELIVERY ROOM & LABOR ROOM	52.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/20/2015 9:54 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	LABORATORY MISCELLANEOUS REVENUE	B	-854	LABORATORY	60.00	0	33.01
33.02	RESPIRATORY MISCELLANEOUS REVENUE	B	-1,305	RESPIRATORY THERAPY	65.00	0	33.02
33.03	OR MISCELLANEOUS REVENUE	B	-700	OPERATING ROOM	50.00	0	33.03
33.04	PHYSICAL THERAPY MISCELLANEOUS REVE	B	-52,546	PHYSICAL THERAPY	66.00	0	33.04
33.05	SPEECH THERAPY MISCELLANEOUS REVENUE	B	-500	SPEECH PATHOLOGY	68.00	0	33.05
33.06	MISCELLANEOUS REVENUE	B	-533	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MANAGEMENT FEE REVENUE	B	-15,360	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	CRNA SALARIES	A	-779,928	ANESTHESIOLOGY	53.00	0	33.08
33.09	CRNA BENEFITS EXPENSE	A	-82,933	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	MARKETING SALARY	A	-37,658	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	MARKETING BENEFITS EXPENSE	A	-7,577	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	MARKETING OTHER EXPENSE	A	-50,021	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	ADVERTISING EXPENSE	A	-55,940	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	LOBBYING EXPENSE	A	-19,345	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	PROVIDER TAX	A	-842,849	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	PROVIDER TAX ASSISTANCE PAYMENT	A	-1,000	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	FUNDED DEPRECIATION TRUSTEE FEES	A	23,775	ADMINISTRATIVE & GENERAL	5.00	0	33.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,669,111				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141322	Period: From 10/01/2013 To 09/30/2014	Worksheet A-8-1 Date/Time Prepared: 2/20/2015 9:54 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HO BUILDING CAPITAL	7,793	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO MME CAPITAL	164,158	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HO INTEREST OPERATING	20,021	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HO MANAGEMENT OPERATING	2,573,634	2,400,549	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	SELF INSURANCE BENEFITS	1,316,527	1,949,695	4.01
4.02	14.00	CENTRAL SERVICES & SUPPLY	PRINT SHOP & SUPPLIES - MMC	98,986	98,986	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,181,119	4,449,230	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B		0.00	MEMORIAL HL SYS	100.00	6.00
7.00	B		0.00	MEMORIAL MD CTR	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141322	Period: From 10/01/2013 To 09/30/2014	Worksheet A-8-1 Date/Time Prepared: 2/20/2015 9:54 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	7,793	9		1.00
2.00	164,158	9		2.00
3.00	20,021	0		3.00
4.00	173,085	0		4.00
4.01	-633,168	0		4.01
4.02	0	0		4.02
5.00	-268,111			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	MANAGEMENT/HO		6.00
7.00	HOSPITAL		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 2/20/2015 9:54 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	6,270	0	6,270	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	1,786	0	1,786	0	0	2.00
3.00	50.00	OPERATING ROOM	38,605	0	38,605	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	311,547	0	311,547	0	0	4.00
5.00	60.00	LABORATORY	19,624	19,624	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	720	0	720	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	1,400	0	1,400	0	0	7.00
8.00	76.97	CARDIAC REHABILITATION	4,400	0	4,400	0	0	8.00
9.00	91.00	EMERGENCY	1,942,535	1,762,469	180,066	0	0	9.00
10.00	91.00	EMERGENCY	55,000	0	55,000	0	0	10.00
200.00			2,381,887	1,782,093	599,794		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0		2.00
3.00	50.00	OPERATING ROOM	0	0	0	0		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0		4.00
5.00	60.00	LABORATORY	0	0	0	19,624		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0		7.00
8.00	76.97	CARDIAC REHABILITATION	0	0	0	0		8.00
9.00	91.00	EMERGENCY	0	0	0	1,762,469		9.00
10.00	91.00	EMERGENCY	0	0	0	0		10.00
200.00			0	0	0	1,782,093		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I Date/Time Prepared: 2/20/2015 9:54 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,102,288	5,102,288				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,502,974		1,502,974			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,226,866	5,041	0	4,231,907		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,220,087	360,220	278,358	535,121	6,393,786	5.00
7.00	00700	OPERATION OF PLANT	1,093,883	1,597,981	60,943	152,996	2,905,803	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	178,265	24,690	0	12,623	215,578	8.00
9.00	00900	HOUSEKEEPING	423,867	138,099	0	116,755	678,721	9.00
10.00	01000	DIETARY	296,480	184,764	21,693	59,510	562,447	10.00
11.00	01100	CAFETERIA	403,325	0	38,788	106,404	548,517	11.00
13.00	01300	NURSING ADMINISTRATION	310,503	8,919	0	102,413	421,835	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	337,495	101,818	1,130	65,148	505,591	14.00
15.00	01500	PHARMACY	467,209	55,972	2,380	147,522	673,083	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	516,348	78,206	0	135,783	730,337	16.00
17.00	01700	SOCIAL SERVICE	36,450	0	0	0	36,450	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,457,554	798,000	59,171	689,535	4,004,260	30.00
43.00	04300	NURSERY	107,583	16,029	648	29,411	153,671	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,430,137	446,613	185,110	308,209	2,370,069	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	97,311	18,313	38,738	26,617	180,979	52.00
53.00	05300	ANESTHESIOLOGY	356,356	13,099	26,020	0	395,475	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,801,081	323,423	631,300	408,603	3,164,407	54.00
60.00	06000	LABORATORY	1,782,252	194,286	50,754	268,815	2,296,107	60.00
65.00	06500	RESPIRATORY THERAPY	430,926	38,952	18,581	119,306	607,765	65.00
66.00	06600	PHYSICAL THERAPY	1,291,977	218,545	23,439	433,869	1,967,830	66.00
68.00	06800	SPEECH PATHOLOGY	81,089	4,654	0	27,529	113,272	68.00
69.00	06900	ELECTROCARDIOLOGY	145,600	7,713	26,199	19,013	198,525	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	169,238	0	0	0	169,238	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	399,640	0	0	0	399,640	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,217,494	0	0	0	1,217,494	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	138,600	168,692	0	40,565	347,857	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,707,969	258,402	39,722	426,160	2,432,253	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)	33,730,847	5,062,431	1,502,974	4,231,907	33,690,990	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	39,857	0	0	39,857	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	33,730,847	5,102,288	1,502,974	4,231,907	33,730,847	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I Date/Time Prepared: 2/20/2015 9:54 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,393,786					5.00
7.00	00700	OPERATION OF PLANT	679,630	3,585,433				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	50,421	28,201	294,200			8.00
9.00	00900	HOUSEKEEPING	158,744	157,737	0	995,202		9.00
10.00	01000	DIETARY	131,549	211,038	425	61,781	967,240	10.00
11.00	01100	CAFETERIA	128,291	0	760	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	98,662	10,188	0	2,982	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	118,251	116,297	0	34,046	0	14.00
15.00	01500	PHARMACY	157,425	63,932	541	18,716	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	170,816	89,327	0	26,150	0	16.00
17.00	01700	SOCIAL SERVICE	8,525	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	936,547	911,479	86,581	266,837	958,542	30.00
43.00	04300	NURSERY	35,942	18,308	2,834	5,360	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	554,328	510,124	40,736	149,339	8,698	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	42,329	20,917	2,565	6,123	0	52.00
53.00	05300	ANESTHESIOLOGY	92,496	14,962	0	4,380	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	740,114	369,415	39,592	108,146	0	54.00
60.00	06000	LABORATORY	537,030	221,915	4	64,966	0	60.00
65.00	06500	RESPIRATORY THERAPY	142,148	44,491	0	13,025	0	65.00
66.00	06600	PHYSICAL THERAPY	460,250	249,623	35,240	73,077	0	66.00
68.00	06800	SPEECH PATHOLOGY	26,493	5,315	0	1,556	0	68.00
69.00	06900	ELECTROCARDIOLOGY	46,432	8,810	4,649	2,579	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	39,583	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	93,471	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	284,756	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	81,359	192,681	0	56,407	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	568,872	295,148	70,232	86,405	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,384,464	3,539,908	284,159	981,875	967,240	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,322	45,525	0	13,327	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	10,041	0	0	192.00
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)	6,393,786	3,585,433	294,200	995,202	967,240	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/20/2015 9:54 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	677,568					11.00
13.00	01300	NURSING ADMINISTRATION	14,872	548,539				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	21,059	828	796,072			14.00
15.00	01500	PHARMACY	19,284	0	1,835	934,816		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,592	0	24	0	1,061,246	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	154,906	278,474	55,903	0	162,669	30.00
43.00	04300	NURSERY	5,020	9,003	874	0	12,534	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,666	103,716	103,778	28	99,718	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,529	8,145	791	0	5,014	52.00
53.00	05300	ANESTHESIOLOGY	12,607	0	10,206	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,235	0	45,697	30,823	89,691	54.00
60.00	06000	LABORATORY	70,180	0	272,000	0	80,220	60.00
65.00	06500	RESPIRATORY THERAPY	24,024	0	3,869	0	22,005	65.00
66.00	06600	PHYSICAL THERAPY	78,935	0	5,836	0	32,868	66.00
68.00	06800	SPEECH PATHOLOGY	4,039	0	0	0	1,393	68.00
69.00	06900	ELECTROCARDIOLOGY	3,946	0	760	0	15,041	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71,016	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	167,697	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	903,965	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	7,097	0	924	0	2,507	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	82,577	148,373	54,862	0	486,334	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)	677,568	548,539	796,072	934,816	1,009,994	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	0	0	0	51,252	192.00
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)	677,568	548,539	796,072	934,816	1,061,246	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/20/2015 9:54 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	44,975					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	7,816,198	0	7,816,198		30.00
43.00	04300	NURSERY	0	243,546	0	243,546		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,998,200	0	3,998,200		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	271,392	0	271,392		52.00
53.00	05300	ANESTHESIOLOGY	0	530,126	0	530,126		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,660,120	0	4,660,120		54.00
60.00	06000	LABORATORY	0	3,542,422	0	3,542,422		60.00
65.00	06500	RESPIRATORY THERAPY	0	857,327	0	857,327		65.00
66.00	06600	PHYSICAL THERAPY	0	2,903,659	0	2,903,659		66.00
68.00	06800	SPEECH PATHOLOGY	0	152,068	0	152,068		68.00
69.00	06900	ELECTROCARDIOLOGY	0	280,742	0	280,742		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	279,837	0	279,837		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	660,808	0	660,808		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,406,215	0	2,406,215		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	688,832	0	688,832		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	44,975	4,270,031	0	4,270,031		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)	44,975	33,561,523	0	33,561,523		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	108,031	0	108,031		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	61,293	0	61,293		192.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	44,975	33,730,847	0	33,730,847		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/20/2015 9:54 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,041	0	5,041	5,041	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,358	360,220	278,358	652,936	638	5.00
7.00	00700	OPERATION OF PLANT	9,876	1,597,981	60,943	1,668,800	182	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	24,690	0	24,690	15	8.00
9.00	00900	HOUSEKEEPING	0	138,099	0	138,099	139	9.00
10.00	01000	DIETARY	0	184,764	21,693	206,457	71	10.00
11.00	01100	CAFETERIA	0	0	38,788	38,788	127	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,919	0	8,919	122	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,158	101,818	1,130	104,106	78	14.00
15.00	01500	PHARMACY	0	55,972	2,380	58,352	176	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	78,206	0	78,206	162	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,097	798,000	59,171	862,268	819	30.00
43.00	04300	NURSERY	0	16,029	648	16,677	35	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,594	446,613	185,110	676,317	367	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	18,313	38,738	57,051	32	52.00
53.00	05300	ANESTHESIOLOGY	3,096	13,099	26,020	42,215	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	120	323,423	631,300	954,843	487	54.00
60.00	06000	LABORATORY	410	194,286	50,754	245,450	320	60.00
65.00	06500	RESPIRATORY THERAPY	861	38,952	18,581	58,394	142	65.00
66.00	06600	PHYSICAL THERAPY	132	218,545	23,439	242,116	517	66.00
68.00	06800	SPEECH PATHOLOGY	0	4,654	0	4,654	33	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,713	26,199	33,912	23	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	168,692	0	168,692	48	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	258,402	39,722	298,124	508	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)	79,702	5,062,431	1,502,974	6,645,107	5,041	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	39,857	0	39,857	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	79,702	5,102,288	1,502,974	6,684,964	5,041	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/20/2015 9:54 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	653,574					5.00
7.00	00700	OPERATION OF PLANT	69,472	1,738,454				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,154	13,674	43,533			8.00
9.00	00900	HOUSEKEEPING	16,227	76,481	0	230,946		9.00
10.00	01000	DIETARY	13,447	102,325	63	14,337	336,700	10.00
11.00	01100	CAFETERIA	13,114	0	112	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	10,085	4,940	0	692	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,088	56,389	0	7,901	0	14.00
15.00	01500	PHARMACY	16,092	30,998	80	4,343	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,461	43,312	0	6,068	0	16.00
17.00	01700	SOCIAL SERVICE	871	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	95,733	441,946	12,810	61,923	333,672	30.00
43.00	04300	NURSERY	3,674	8,877	419	1,244	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	56,664	247,341	6,028	34,655	3,028	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,327	10,142	380	1,421	0	52.00
53.00	05300	ANESTHESIOLOGY	9,455	7,254	0	1,016	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	75,655	179,117	5,859	25,096	0	54.00
60.00	06000	LABORATORY	54,895	107,599	1	15,076	0	60.00
65.00	06500	RESPIRATORY THERAPY	14,530	21,572	0	3,023	0	65.00
66.00	06600	PHYSICAL THERAPY	47,047	121,034	5,215	16,958	0	66.00
68.00	06800	SPEECH PATHOLOGY	2,708	2,577	0	361	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,746	4,272	688	598	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,046	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,555	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,108	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	8,317	93,424	0	13,090	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	58,150	143,107	10,392	20,051	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)	652,621	1,716,381	42,047	227,853	336,700	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	953	22,073	0	3,093	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,486	0	0	192.00
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)	653,574	1,738,454	43,533	230,946	336,700	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/20/2015 9:54 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	52,141					11.00
13.00	01300	NURSING ADMINISTRATION	1,144	25,902				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,621	39	182,222			14.00
15.00	01500	PHARMACY	1,484	0	420	111,945		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,432	0	6	0	148,647	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,918	13,150	12,796	0	22,785	30.00
43.00	04300	NURSERY	386	425	200	0	1,756	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,438	4,897	23,755	3	13,967	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	349	385	181	0	702	52.00
53.00	05300	ANESTHESIOLOGY	970	0	2,336	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,559	0	10,460	3,691	12,563	54.00
60.00	06000	LABORATORY	5,401	0	62,260	0	11,236	60.00
65.00	06500	RESPIRATORY THERAPY	1,849	0	886	0	3,082	65.00
66.00	06600	PHYSICAL THERAPY	6,074	0	1,336	0	4,604	66.00
68.00	06800	SPEECH PATHOLOGY	311	0	0	0	195	68.00
69.00	06900	ELECTROCARDIOLOGY	304	0	174	0	2,107	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	16,256	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	38,386	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	108,251	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	546	0	212	0	351	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,355	7,006	12,558	0	68,120	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)	52,141	25,902	182,222	111,945	141,468	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	0	0	0	7,179	192.00
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)	52,141	25,902	182,222	111,945	148,647	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/20/2015 9:54 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	871					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,869,820	0	1,869,820		30.00
43.00	04300	NURSERY	0	33,693	0	33,693		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,071,460	0	1,071,460		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	74,970	0	74,970		52.00
53.00	05300	ANESTHESIOLOGY	0	63,246	0	63,246		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,273,330	0	1,273,330		54.00
60.00	06000	LABORATORY	0	502,238	0	502,238		60.00
65.00	06500	RESPIRATORY THERAPY	0	103,478	0	103,478		65.00
66.00	06600	PHYSICAL THERAPY	0	444,901	0	444,901		66.00
68.00	06800	SPEECH PATHOLOGY	0	10,839	0	10,839		68.00
69.00	06900	ELECTROCARDIOLOGY	0	46,824	0	46,824		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,302	0	20,302		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	47,941	0	47,941		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	137,359	0	137,359		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	284,680	0	284,680		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	871	625,242	0	625,242		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)	871	6,610,323	0	6,610,323		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	65,976	0	65,976		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,665	0	8,665		192.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	871	6,684,964	0	6,684,964		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/20/2015 9:54 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	118,414					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,499,295				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	117	0	12,542,392			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,360	277,677	1,585,976	-6,393,786	27,337,061	5.00
7.00	00700	OPERATION OF PLANT	37,086	60,794	453,444	0	2,905,803	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	573	0	37,411	0	215,578	8.00
9.00	00900	HOUSEKEEPING	3,205	0	346,036	0	678,721	9.00
10.00	01000	DIETARY	4,288	21,640	176,374	0	562,447	10.00
11.00	01100	CAFETERIA	0	38,693	315,357	0	548,517	11.00
13.00	01300	NURSING ADMINISTRATION	207	0	303,530	0	421,835	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,363	1,127	193,084	0	505,591	14.00
15.00	01500	PHARMACY	1,299	2,374	437,220	0	673,083	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,815	0	402,430	0	730,337	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	36,450	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,520	59,026	2,043,613	0	4,004,260	30.00
43.00	04300	NURSERY	372	646	87,166	0	153,671	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,365	184,657	913,462	0	2,370,069	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	425	38,643	78,887	0	180,979	52.00
53.00	05300	ANESTHESIOLOGY	304	25,956	0	0	395,475	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,506	629,754	1,211,006	0	3,164,407	54.00
60.00	06000	LABORATORY	4,509	50,630	796,707	0	2,296,107	60.00
65.00	06500	RESPIRATORY THERAPY	904	18,536	353,596	0	607,765	65.00
66.00	06600	PHYSICAL THERAPY	5,072	23,382	1,285,888	0	1,967,830	66.00
68.00	06800	SPEECH PATHOLOGY	108	0	81,589	0	113,272	68.00
69.00	06900	ELECTROCARDIOLOGY	179	26,135	56,349	0	198,525	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	169,238	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	399,640	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,217,494	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,915	0	120,226	0	347,857	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,997	39,625	1,263,041	0	2,432,253	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	117,489	1,499,295	12,542,392	-6,393,786	27,297,204	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	925	0	0	0	39,857	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,102,288	1,502,974	4,231,907		6,393,786	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	43.088554	1.002454	0.337408		0.233887	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,041		653,574	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000402		0.023908	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/20/2015 9:54 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	72,851					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	573	202,198				8.00
9.00	00900	HOUSEKEEPING	3,205	0	69,073			9.00
10.00	01000	DIETARY	4,288	292	4,288	23,576		10.00
11.00	01100	CAFETERIA	0	522	0	0	29,022	11.00
13.00	01300	NURSING ADMINISTRATION	207	0	207	0	637	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,363	0	2,363	0	902	14.00
15.00	01500	PHARMACY	1,299	372	1,299	0	826	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,815	0	1,815	0	1,910	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,520	59,505	18,520	23,364	6,635	30.00
43.00	04300	NURSERY	372	1,948	372	0	215	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,365	27,997	10,365	212	2,470	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	425	1,763	425	0	194	52.00
53.00	05300	ANESTHESIOLOGY	304	0	304	0	540	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,506	27,211	7,506	0	3,094	54.00
60.00	06000	LABORATORY	4,509	3	4,509	0	3,006	60.00
65.00	06500	RESPIRATORY THERAPY	904	0	904	0	1,029	65.00
66.00	06600	PHYSICAL THERAPY	5,072	24,220	5,072	0	3,381	66.00
68.00	06800	SPEECH PATHOLOGY	108	0	108	0	173	68.00
69.00	06900	ELECTROCARDIOLOGY	179	3,195	179	0	169	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,915	0	3,915	0	304	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,997	48,269	5,997	0	3,537	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	71,926	195,297	68,148	23,576	29,022	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	925	0	925	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,901	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,585,433	294,200	995,202	967,240	677,568	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	49.215975	1.455009	14.407974	41.026468	23.346703	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,738,454	43,533	230,946	336,700	52,141	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	23.863145	0.215299	3.343506	14.281473	1.796603	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/20/2015 9:54 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	146,406					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	221	1,897,128				14.00
15.00	01500	PHARMACY	0	4,373	1,206,793			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	58	0	3,810		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	344	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	74,325	133,222	0	584	0	30.00
43.00	04300	NURSERY	2,403	2,084	0	45	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,682	247,314	36	358	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,174	1,886	0	18	0	52.00
53.00	05300	ANESTHESIOLOGY	0	24,321	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	108,902	39,791	322	0	54.00
60.00	06000	LABORATORY	0	648,206	0	288	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,220	0	79	0	65.00
66.00	06600	PHYSICAL THERAPY	0	13,908	0	118	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	5	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,812	0	54	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	169,238	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	399,640	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,166,966	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,202	0	9	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	39,601	130,742	0	1,746	344	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)	146,406	1,897,128	1,206,793	3,626	344	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	0	0	184	0	192.00
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)	548,539	796,072	934,816	1,061,246	44,975	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.746698	0.419620	0.774628	278.542257	130.741279	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	25,902	182,222	111,945	148,647	871	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.176919	0.096052	0.092762	39.014961	2.531977	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/20/2015 9:54 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,816,198		7,816,198	0	0	30.00
43.00	04300	NURSERY	243,546		243,546	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,998,200		3,998,200	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	271,392		271,392	0	0	52.00
53.00	05300	ANESTHESIOLOGY	530,126		530,126	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,660,120		4,660,120	0	0	54.00
60.00	06000	LABORATORY	3,542,422		3,542,422	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	857,327	0	857,327	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,903,659	0	2,903,659	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	152,068	0	152,068	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	280,742		280,742	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	279,837		279,837	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	660,808		660,808	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,406,215		2,406,215	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	688,832		688,832	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,270,031		4,270,031	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	260,226		260,226		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	33,821,749	0	33,821,749	0	0	200.00
201.00		Less Observation Beds	260,226		260,226		0	201.00
202.00		Total (see instructions)	33,561,523	0	33,561,523	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/20/2015 9:54 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,841,762		4,841,762			30.00
43.00	04300	NURSERY	340,023		340,023			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,510,676	5,798,331	7,309,007	0.547024	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	776,503	1,073,699	1,850,202	0.146682	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	404,420	929,645	1,334,065	0.397376	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,485,599	26,732,820	28,218,419	0.165145	0.000000	54.00
60.00	06000	LABORATORY	1,907,773	11,057,173	12,964,946	0.273231	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	404,539	1,305,495	1,710,034	0.501351	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	467,412	4,385,119	4,852,531	0.598380	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	53,369	168,753	222,122	0.684615	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	394,544	1,177,670	1,572,214	0.178565	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,004,305	1,028,320	2,032,625	0.137673	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,468,031	592,436	2,060,467	0.320708	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,722,670	5,972,477	8,695,147	0.276731	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	152	641,233	641,385	1.073976	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	485,157	9,801,981	10,287,138	0.415084	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,212	260,439	261,651	0.994554	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,268,147	70,925,591	89,193,738			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	18,268,147	70,925,591	89,193,738			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/20/2015 9:54 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part II Date/Time Prepared: 2/20/2015 9:54 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,071,460	7,309,007	0.146594	457,852	67,118	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	74,970	1,850,202	0.040520	2,405	97	52.00
53.00	05300	ANESTHESIOLOGY	63,246	1,334,065	0.047408	113,627	5,387	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,273,330	28,218,419	0.045124	911,438	41,128	54.00
60.00	06000	LABORATORY	502,238	12,964,946	0.038738	922,091	35,720	60.00
65.00	06500	RESPIRATORY THERAPY	103,478	1,710,034	0.060512	291,484	17,638	65.00
66.00	06600	PHYSICAL THERAPY	444,901	4,852,531	0.091684	205,602	18,850	66.00
68.00	06800	SPEECH PATHOLOGY	10,839	222,122	0.048798	32,513	1,587	68.00
69.00	06900	ELECTROCARDIOLOGY	46,824	1,572,214	0.029782	269,634	8,030	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,302	2,032,625	0.009988	474,963	4,744	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,941	2,060,467	0.023267	724,514	16,857	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	137,359	8,695,147	0.015797	1,085,206	17,143	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	284,680	641,385	0.443852	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	625,242	10,287,138	0.060779	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	74,813	261,651	0.285927	0	0	92.00
200.00		Total (lines 50-199)	4,781,623	84,011,953		5,491,329	234,299	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/20/2015 9:54 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV Date/Time Prepared: 2/20/2015 9:54 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,309,007	0.000000	0.000000	457,852	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,850,202	0.000000	0.000000	2,405	52.00
53.00	05300	ANESTHESIOLOGY	0	1,334,065	0.000000	0.000000	113,627	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,218,419	0.000000	0.000000	911,438	54.00
60.00	06000	LABORATORY	0	12,964,946	0.000000	0.000000	922,091	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,710,034	0.000000	0.000000	291,484	65.00
66.00	06600	PHYSICAL THERAPY	0	4,852,531	0.000000	0.000000	205,602	66.00
68.00	06800	SPEECH PATHOLOGY	0	222,122	0.000000	0.000000	32,513	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,572,214	0.000000	0.000000	269,634	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,032,625	0.000000	0.000000	474,963	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,060,467	0.000000	0.000000	724,514	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,695,147	0.000000	0.000000	1,085,206	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	641,385	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	10,287,138	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	261,651	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	84,011,953			5,491,329	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/20/2015 9:54 am

Title XVIII | Hospital | Cost

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/20/2015 9:54 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.547024	0	2,054,127	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.146682	0	42,032	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.397376	0	240,137	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.165145	0	8,972,796	0	0	54.00
60.00	06000	LABORATORY	0.273231	0	3,886,517	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.501351	0	338,708	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.598380	0	1,404,502	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.684615	0	27,148	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.178565	0	489,244	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.137673	0	296,912	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.320708	0	276,260	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276731	0	3,167,964	1,770	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.073976	0	355,984	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.415084	0	2,751,222	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.994554	0	136,645	0	0	92.00
200.00		Subtotal (see instructions)		0	24,440,198	1,770	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	24,440,198	1,770	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/20/2015 9:54 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,123,657	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,165	0		52.00
53.00	05300	ANESTHESIOLOGY	95,425	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,481,812	0		54.00
60.00	06000	LABORATORY	1,061,917	0		60.00
65.00	06500	RESPIRATORY THERAPY	169,812	0		65.00
66.00	06600	PHYSICAL THERAPY	840,426	0		66.00
68.00	06800	SPEECH PATHOLOGY	18,586	0		68.00
69.00	06900	ELECTROCARDIOLOGY	87,362	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,877	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,599	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	876,674	490		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	382,318	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,141,988	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	135,901	0		92.00
200.00		Subtotal (see instructions)	7,551,519	490		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	7,551,519	490		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141322 | Component CCN: 14Z322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V | Date/Time Prepared: 2/20/2015 9:54 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.547024	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.146682	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.397376	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.165145	0	0	0	0	54.00
60.00	06000	LABORATORY	0.273231	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.501351	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.598380	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.684615	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.178565	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.137673	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.320708	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276731	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.073976	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.415084	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.994554	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141322 | Component CCN: 14Z322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V | Date/Time Prepared: 2/20/2015 9:54 am

Title XVIII | Swing Beds - SNF | Cost

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/20/2015 9:54 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,401	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,649	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,503	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	203	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)	532	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	5	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)	12	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,876	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)	203	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)	420	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	134.54	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.54	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,816,198	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)	673	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)	1,614	25.00
26.00	Total swing-bed cost (see instructions)	1,312,329	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,503,869	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,503,869	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)	1,782.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,343,726	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)	3,343,726	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/20/2015 9:54 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,636,052	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,979,778	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)	361,821	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	748,595	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,110,416	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)	146	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,782.37	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	260,226	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/20/2015 9:54 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,869,820	6,503,869	0.287493	260,226	74,813	90.00
91.00	Nursing School cost	0	6,503,869	0.000000	260,226	0	91.00
92.00	Allied health cost	0	6,503,869	0.000000	260,226	0	92.00
93.00	All other Medical Education	0	6,503,869	0.000000	260,226	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/20/2015 9:54 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,255,727		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.547024	457,852	250,456	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.146682	2,405	353	52.00
53.00	05300	ANESTHESIOLOGY	0.397376	113,627	45,153	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.165145	911,438	150,519	54.00
60.00	06000	LABORATORY	0.273231	922,091	251,944	60.00
65.00	06500	RESPIRATORY THERAPY	0.501351	291,484	146,136	65.00
66.00	06600	PHYSICAL THERAPY	0.598380	205,602	123,028	66.00
68.00	06800	SPEECH PATHOLOGY	0.684615	32,513	22,259	68.00
69.00	06900	ELECTROCARDIOLOGY	0.178565	269,634	48,147	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.137673	474,963	65,390	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.320708	724,514	232,357	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276731	1,085,206	300,310	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.073976	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.415084	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.994554	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		5,491,329	1,636,052	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		5,491,329		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141322 | Component CCN: 14Z322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/20/2015 9:54 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.547024	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.146682	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.397376	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.165145	73,250	12,097	54.00
60.00	06000	LABORATORY	0.273231	152,207	41,588	60.00
65.00	06500	RESPIRATORY THERAPY	0.501351	102,663	51,470	65.00
66.00	06600	PHYSICAL THERAPY	0.598380	122,826	73,497	66.00
68.00	06800	SPEECH PATHOLOGY	0.684615	14,327	9,808	68.00
69.00	06900	ELECTROCARDIOLOGY	0.178565	17,429	3,112	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.137673	141,096	19,425	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.320708	228,829	73,387	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276731	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.073976	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.415084	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.994554	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		852,627	284,384	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)		852,627		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141322	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part B Date/Time Prepared: 2/20/2015 9:54 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,552,009	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)	7,552,009	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)	7,627,529	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	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)	45,833	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4,132,509	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)	3,449,187	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)	3,449,187	30.00
31.00	Primary payer payments	873	31.00
32.00	Subtotal (line 30 minus line 31)	3,448,314	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)	988,325	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	751,127	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	849,880	36.00
37.00	Subtotal (see instructions)	4,199,441	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,199,441	40.00
40.01	Sequestration adjustment (see instructions)	83,989	40.01
41.00	Interim payments	4,110,433	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	5,019	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 2/20/2015 9:54 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,178,200		4,947,689	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	09/29/2014	405,075		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	05/30/2014	196,535	05/30/2014	473,941	3.50
3.51			0	09/29/2014	363,315	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)		208,540		-837,256	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)		4,386,740		4,110,433	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		137,210		5,019	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,523,950		4,115,452	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 2/20/2015 9:54 am

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

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,330,513		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	05/30/2014	101,907		0	3.50
3.51		09/29/2014	117,015		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)		-218,922		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,111,591		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		261,550		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,373,141		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141322	Period: From 10/01/2013 To 09/30/2014	Worksheet E-1 Part II Date/Time Prepared: 2/20/2015 9:54 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	1,092	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	1,876	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	120	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	3,503	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	89,193,738	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	3,195,275	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	613,130	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	484,986	8.00
9.00	Sequestration adjustment amount (see instructions)	9,700	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	475,286	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	475,286	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141322 | Component CCN: 14Z322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E-2 | Date/Time Prepared: 2/20/2015 9:54 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,121,520	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)	287,228	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	623	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,408,748	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,408,748	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,408,748	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,584	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,401,164	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	RURAL DEMONSTRATION PROJECT	0		16.50
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,401,164	0	19.00
19.01	Sequestration adjustment (see instructions)	28,023	0	19.01
20.00	Interim payments	1,111,591	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	261,550	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141322	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part V Date/Time Prepared: 2/20/2015 9:54 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,979,778	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	4,979,778	4.00
5.00	Primary payer payments	8,201	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,021,375	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 physicians' services in a teaching hospital (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)	5,021,375	19.00
20.00	Deductibles (exclude professional component)	497,792	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,523,583	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	4,523,583	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	121,964	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	92,693	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	97,231	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,616,276	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)	4,616,276	30.00
30.01	Sequestration adjustment (see instructions)	92,326	30.01
31.00	Interim payments	4,386,740	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	137,210	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G | Date/Time Prepared: 2/20/2015 9:54 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	16,667,633	0	0	0	1.00
2.00	Temporary investments	7,010,687	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,087,908	0	0	0	4.00
5.00	Other receivable	112,917	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,091,145	0	0	0	6.00
7.00	Inventory	504,088	0	0	0	7.00
8.00	Prepaid expenses	176,313	0	0	0	8.00
9.00	Other current assets	1,134,613	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	31,603,014	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	834,848	0	0	0	12.00
13.00	Land improvements	5,976,844	0	0	0	13.00
14.00	Accumulated depreciation	-1,800,669	0	0	0	14.00
15.00	Buildings	42,142,744	0	0	0	15.00
16.00	Accumulated depreciation	-9,633,411	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	13,834,976	0	0	0	23.00
24.00	Accumulated depreciation	-9,571,398	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	1,912,947	0	0	0	27.00
28.00	Accumulated depreciation	-419,436	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)	43,277,445	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	21,689,445	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	643,551	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	22,332,996	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	97,213,455	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,068,360	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,191,400	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	173,817	0	0	0	40.00
41.00	Deferred income	1,134,614	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	3,173,815	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,742,006	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	42,018,315	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	42,018,315	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	48,760,321	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	48,453,134				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)	48,453,134	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	97,213,455	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-1 | Date/Time Prepared: 2/20/2015 9:54 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		41,413,138		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7,039,996				2.00
3.00	Total (sum of line 1 and line 2)		48,453,134		0		3.00
4.00		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)		48,453,134		0		11.00
12.00		0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		48,453,134		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			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			0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/20/2015 9:54 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,675,103		3,675,103	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	405,979		405,979	5.00
6.00	Swing bed - NF	15,715		15,715	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,096,797		4,096,797	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,096,797		4,096,797	17.00
18.00	Ancillary services	15,174,924	81,651,195	96,826,119	18.00
19.00	Outpatient services	0	57,129	57,129	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	19,271,721	81,708,324	100,980,045	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,399,958		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		38,399,958		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141322 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-3 | Date/Time Prepared: 2/20/2015 9:54 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	100,980,045	1.00
2.00	Less contractual allowances and discounts on patients' accounts	60,989,393	2.00
3.00	Net patient revenues (line 1 minus line 2)	39,990,652	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,399,958	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,590,694	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	185,350	6.00
7.00	Income from investments	1,159,422	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	126,783	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	1,999	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	2,693,557	23.00
24.00	MISCELLANEOUS INCOME	56,491	24.00
24.01	MEANINGFUL USE INCOME	440,150	24.01
24.02	MANAGEMENT SUPPORT	15,360	24.02
24.03	UNREALIZED GAINS	770,806	24.03
25.00	Total other income (sum of lines 6-24)	5,449,918	25.00
26.00	Total (line 5 plus line 25)	7,040,612	26.00
27.00	LOSS ON DISPOSAL OF ASSETS	616	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	616	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	7,039,996	29.00