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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141339	Period: From 10/01/2013 To 09/30/2014	Worksheet S Parts I-III Date/Time Prepared: 2/17/2015 9:11 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/17/2015 Time: 9:11 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 TAYLORVILLE MEMORIAL HOSPITAL (141339) 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)

TAYLORVILLE MEMORIAL HOSPITAL
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	-99,294	603,648	38,846	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	26,830	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	-72,464	603,648	38,846	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 2/17/2015 9:09 am

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

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

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2013	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.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/17/2015 9:09 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.	N			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.	N			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: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/17/2015 9:09 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: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/17/2015 9:09 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)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have 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)	N	N	0	76.00

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

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

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		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.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	129,190	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

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		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 HEALTH SYSTEMS	Contractor's Name: MEMORIAL HEALTH SYSTEMS	Contractor's Number: 00131	141.00
142.00	Street: 701 NORTH FIRST STREET	PO Box:		142.00
143.00	City: SPRINGFIELD	State: IL	Zip Code: 62781	143.00

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

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

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

		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)	40,300	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: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 2/17/2015 9:09 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: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 2/17/2015 9:09 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: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 2/17/2015 9:09 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: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 2/17/2015 9:09 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	98,619.00	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	98,619.00	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						13.00
14.00	Total (see instructions)		25	9,125	98,619.00	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	44.00	20	7,300		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		45				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 2/17/2015 9:09 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)	3,099	229	4,138			1.00
2.00	HMO and other (see instructions)	0	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	803	0	832			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	237			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,902	229	5,207			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	3,902	229	5,207	0.00	266.74	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	2,849	0	3,934	0.00	19.38	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	286.12	27.00
28.00	Observation Bed Days		0	265			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			42			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 2/17/2015 9:09 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	798	82	1,174	1.00
2.00	HMO and other (see instructions)			0	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	798	82	1,174	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-7 | Date/Time Prepared: 2/17/2015 9:09 am

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	43	0	43	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	49	0	49	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	151	0	151	12.00
13.00		RUB	216	0	216	13.00
14.00		RUA	347	0	347	14.00
15.00		RVC	265	0	265	15.00
16.00		RVB	336	0	336	16.00
17.00		RVA	774	0	774	17.00
18.00		RHC	287	0	287	18.00
19.00		RHB	220	0	220	19.00
20.00		RHA	90	0	90	20.00
21.00		RMC	20	0	20	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	8	0	8	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	12	0	12	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	8	0	8	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	3	0	3	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	15	0	15	51.00
52.00		CB1	3	0	3	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-7 | Date/Time Prepared: 2/17/2015 9:09 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	2	0	2	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		2,849	0	2,849	200.00

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

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	827,642	144.72	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	675	0.12	Y	205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	571,907			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-10 | Date/Time Prepared: 2/17/2015 9:09 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)	0.384342	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,238,054	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,776,774	5.00
6.00	Medicaid charges	11,943,315	6.00
7.00	Medicaid cost (line 1 times line 6)	4,590,318	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)	575,490	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	20,945	9.00
10.00	Stand-alone SCHIP charges	88,704	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	34,093	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	13,148	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)	588,638	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	1,638,455	1,976,939	3,615,394	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	629,727	759,821	1,389,548	21.00
22.00	Partial payment by patients approved for charity care	17,393	0	17,393	22.00
23.00	Cost of charity care (line 21 minus line 22)	612,334	759,821	1,372,155	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)	475,597	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	853,469	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	-377,872	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	-145,232	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,226,923	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,815,561	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A | Date/Time Prepared: 2/17/2015 9:09 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		1,467,645	1,467,645	959,005	2,426,650	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,598,553	1,598,553	102,047	1,700,600	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	119,381	3,520,120	3,639,501	274,962	3,914,463	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,890,196	4,984,925	6,875,121	-304,252	6,570,869	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	762,649	1,004,856	1,767,505	0	1,767,505	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	85,139	82,922	168,061	0	168,061	8.00
9.00	00900	HOUSEKEEPING	381,786	94,665	476,451	0	476,451	9.00
10.00	01000	DIETARY	461,967	480,549	942,516	-621,402	321,114	10.00
11.00	01100	CAFETERIA	0	0	0	621,402	621,402	11.00
13.00	01300	NURSING ADMINISTRATION	456,527	55,229	511,756	0	511,756	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	46,758	185,229	231,987	0	231,987	14.00
15.00	01500	PHARMACY	398,357	1,224,516	1,622,873	-1,185,715	437,158	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	477,327	97,469	574,796	0	574,796	16.00
17.00	01700	SOCIAL SERVICE	40,997	3,315	44,312	0	44,312	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,985,923	250,325	2,236,248	0	2,236,248	30.00
44.00	04400	SKILLED NURSING FACILITY	747,505	459,791	1,207,296	-362,864	844,432	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	599,356	647,635	1,246,991	-429,736	817,255	50.00
53.00	05300	ANESTHESIOLOGY	588,088	370,725	958,813	-2,376	956,437	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,008,264	895,174	1,903,438	-749	1,902,689	54.00
60.00	06000	LABORATORY	890,603	1,041,421	1,932,024	-86	1,931,938	60.00
65.00	06500	RESPIRATORY THERAPY	467,369	122,963	590,332	-48,338	541,994	65.00
66.00	06600	PHYSICAL THERAPY	959,891	109,789	1,069,680	0	1,069,680	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	362,864	362,864	66.01
68.00	06800	SPEECH PATHOLOGY	102,513	9,674	112,187	0	112,187	68.00
69.00	06900	ELECTROCARDIOLOGY	135,797	41,772	177,569	0	177,569	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	123,740	123,740	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,727	61,915	97,642	374,180	471,822	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,176,627	1,176,627	73.00
76.00	03020	OP PSYCH	80,137	142,848	222,985	0	222,985	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,506,783	2,141,243	3,648,026	-7,547	3,640,479	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,031,762	1,031,762	-1,031,762	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,229,040	22,127,030	36,356,070	0	36,356,070	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	1,432	1,972	3,404	0	3,404	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	14,230,472	22,129,002	36,359,474	0	36,359,474	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A | Date/Time Prepared: 2/17/2015 9:09 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	-172,450	2,254,200		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-53,939	1,646,661		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-999,916	2,914,547		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-550,709	6,020,160		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	1,767,505		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	168,061		8.00
9.00	00900	HOUSEKEEPING	0	476,451		9.00
10.00	01000	DIETARY	0	321,114		10.00
11.00	01100	CAFETERIA	-179,507	441,895		11.00
13.00	01300	NURSING ADMINISTRATION	-2,563	509,193		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	231,987		14.00
15.00	01500	PHARMACY	0	437,158		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-10,512	564,284		16.00
17.00	01700	SOCIAL SERVICE	0	44,312		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-8,938	2,227,310		30.00
44.00	04400	SKILLED NURSING FACILITY	-29,280	815,152		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-31,200	786,055		50.00
53.00	05300	ANESTHESIOLOGY	-934,822	21,615		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-436	1,902,253		54.00
60.00	06000	LABORATORY	0	1,931,938		60.00
65.00	06500	RESPIRATORY THERAPY	-3,600	538,394		65.00
66.00	06600	PHYSICAL THERAPY	0	1,069,680		66.00
66.01	06601	PHYSICAL THERAPY SNF	0	362,864		66.01
68.00	06800	SPEECH PATHOLOGY	0	112,187		68.00
69.00	06900	ELECTROCARDIOLOGY	-25,742	151,827		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	123,740		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	471,822		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,176,627		73.00
76.00	03020	OP PSYCH	0	222,985		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,739,610	1,900,869		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)	-4,743,224	31,612,846		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,404		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-4,743,224	31,616,250		200.00

RECLASSIFICATIONS | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/17/2015 9:09 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS CAFETERIA EXPENSES					
1.00	CAFETERIA	11.00	304,575	316,827		1.00
	TOTALS		304,575	316,827		
	B - TO RECLASS BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,176,627		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		0	1,176,627		
	C - RECLASS PENSION COSTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	274,962		1.00
	TOTALS		0	274,962		
	D - TO RECLASS BILLABLE SUPPLIES/IMPLANT					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	154,596		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	374,180		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	TOTALS		0	528,776		
	E - TO RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	29,290		1.00
	TOTALS		0	29,290		
	F - TO RECLASS SNF THERAPY EXPENSE					
1.00	PHYSICAL THERAPY SNF	66.01	0	362,864		1.00
	TOTALS		0	362,864		
	G - TO RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	942,728		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	89,034		2.00
	TOTALS		0	1,031,762		
500.00	Grand Total: Increases		304,575	3,721,108		500.00

RECLASSIFICATIONS | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/17/2015 9:09 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS CAFETERIA EXPENSES						
1.00	DIETARY	10.00	304,575	316,827	0		1.00
	TOTALS		304,575	316,827			
	B - TO RECLASS BILLABLE DRUGS						
1.00	PHARMACY	15.00	0	1,175,413	0		1.00
2.00	OPERATING ROOM	50.00	0	388	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	740	0		3.00
4.00	LABORATORY	60.00	0	86	0		4.00
	TOTALS		0	1,176,627			
	C - RECLASS PENSION COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	274,962	0		1.00
	TOTALS		0	274,962			
	D - TO RECLASS BILLABLE SUPPLIES/IMPLANT						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	30,856	0		1.00
2.00	PHARMACY	15.00	0	10,302	0		2.00
3.00	OPERATING ROOM	50.00	0	429,348	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	749	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	48,338	0		5.00
6.00	EMERGENCY	91.00	0	7,547	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	1,636	0		7.00
	TOTALS		0	528,776			
	E - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	29,290	0		1.00
	TOTALS		0	29,290			
	F - TO RECLASS SNF THERAPY EXPENSE						
1.00	SKILLED NURSING FACILITY	44.00	0	362,864	0		1.00
	TOTALS		0	362,864			
	G - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,031,762	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	1,031,762			
500.00	Grand Total: Decreases		304,575	3,721,108			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 2/17/2015 9:09 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	737,345	0	0	0	0	1.00
2.00	Land Improvements	3,227,898	192,009	0	192,009	0	2.00
3.00	Buildings and Fixtures	24,666,559	201,043	0	201,043	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	20,046,595	1,007,821	0	1,007,821	0	6.00
7.00	HIT designated Assets	2,110,095	40,300	0	40,300	0	7.00
8.00	Subtotal (sum of lines 1-7)	50,788,492	1,441,173	0	1,441,173	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	50,788,492	1,441,173	0	1,441,173	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	737,345	0	1.00
2.00	Land Improvements	3,419,907	0	2.00
3.00	Buildings and Fixtures	24,867,602	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	21,054,416	0	6.00
7.00	HIT designated Assets	2,150,395	0	7.00
8.00	Subtotal (sum of lines 1-7)	52,229,665	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	52,229,665	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 2/17/2015 9:09 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	1,467,645	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,598,553	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,066,198	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1,467,645		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,598,553		2.00
3.00	Total (sum of lines 1-2)	0	3,066,198		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part III | Date/Time Prepared: 2/17/2015 9:09 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	29,024,854	0	29,024,854	0.555716	16,277	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,204,811	0	23,204,811	0.444284	13,013	2.00
3.00	Total (sum of lines 1-2)	52,229,665	0	52,229,665	1.000000	29,290	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	16,277	1,475,036	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	13,013	1,562,709	0	2.00
3.00	Total (sum of lines 1-2)	0	0	29,290	3,037,745	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	762,887	16,277	0	0	2,254,200	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	70,939	13,013	0	0	1,646,661	2.00
3.00	Total (sum of lines 1-2)	833,826	29,290	0	0	3,900,861	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/17/2015 9:09 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	-179,841	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-18,095	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-3,859	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-1,544	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,089,249			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	-467,190			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-179,507	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	-10,512	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	-191,534	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	PROVIDER TAX EXPENSE	A	-691,188	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	CRNA CONTRACT EXPENSE	A	-76,102	ANESTHESIOLOGY	53.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/17/2015 9:09 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	CRNA SALARY EXPENSE	A	-588,088	ANESTHESIOLOGY	53.00	0	33.02
33.03	CRNA FICA EXPENSE	A	-22,752	ANESTHESIOLOGY	53.00	0	33.03
33.04	CRNA BENEFIT EXPENSE	A	-125,851	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	MARKETING SALARY EXPENSE	A	-18,935	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	MARKETING FICA EXPENSE	A	-1,403	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MARKETING BENEFIT EXPENSE	A	-4,053	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	ADVERTISING EXPENSE	A	-7,736	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	MARKETING OTHER EXPENSE	A	-10,311	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	LOBBYING EXPENSE	A	-19,805	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	MISCELLANEOUS INCOME	B	-34,329	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	PHYSICIAN RECRUITMENT EXPENSE	A	-1,340	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,743,224				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: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8-1 | Date/Time Prepared: 2/17/2015 9:09 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	CAPITAL BLDG HO BLDG CAPTIAL	7,391	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	155,690	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HO INTEREST (OPERATING)	18,988	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	A&G HO MANAGEMENT	2,443,237	2,221,814	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	1,621,879	2,490,551	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	A&G ITEMS - MMC	14,903	14,903	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	A&G PERSONNEL - ALMH	0	1,775	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	A&G PERSONNEL - VAN	0	235	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,262,088	4,729,278	5.00

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

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

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

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

6.00	B		0.00	MEMORIAL HEALTH	100.00	6.00
7.00	B		0.00	MEMORIAL MD CTR	0.00	7.00
8.00	B		0.00	ABRAHAM LINCOLN	0.00	8.00
9.00	B		0.00	MEMORIAL VNA	0.00	9.00
10.00	B		0.00	PASSAVANT	0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141339	Period: From 10/01/2013 To 09/30/2014	Worksheet A-8-1 Date/Time Prepared: 2/17/2015 9:09 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	7,391	9		1.00
2.00	155,690	9		2.00
3.00	18,988	0		3.00
4.00	221,423	0		4.00
4.01	-868,672	0		4.01
4.02	0	0		4.02
4.03	-1,775	0		4.03
4.04	-235	0		4.04
5.00	-467,190			5.00

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

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

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

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

6.00	MANAGEMENT HO		6.00
7.00	HOSPITAL		7.00
8.00	HOSPITAL		8.00
9.00	HOME HEALTH		9.00
10.00	HOSPITAL		10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 2/17/2015 9:09 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	30.00	ADULTS & PEDIATRICS	8,938	8,938	0	0	0	1.00
2.00	44.00	SKILLED NURSING FACILITY	29,280	29,280	0	0	0	2.00
3.00	50.00	OPERATING ROOM	31,200	31,200	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	247,880	247,880	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	436	436	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	3,600	3,600	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	25,742	25,742	0	0	0	7.00
8.00	91.00	EMERGENCY	1,934,987	1,739,610	195,376	0	0	8.00
9.00	13.00	NURSING ADMINISTRATION	2,563	2,563	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,284,626	2,089,249	195,376		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	44.00	SKILLED NURSING FACILITY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	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	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	8,938		1.00
2.00	44.00	SKILLED NURSING FACILITY	0	0	0	29,280		2.00
3.00	50.00	OPERATING ROOM	0	0	0	31,200		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	247,880		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	436		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	3,600		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	25,742		7.00
8.00	91.00	EMERGENCY	0	0	0	1,739,610		8.00
9.00	13.00	NURSING ADMINISTRATION	0	0	0	2,563		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,089,249		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/17/2015 9:09 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	2,254,200	2,254,200				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,646,661		1,646,661			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,914,547	5,688	0	2,920,235		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,020,160	366,837	312,587	404,658	7,104,242	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	106,581	0	0	106,581	6.00
7.00	00700	OPERATION OF PLANT	1,767,505	610,126	41,018	164,922	2,583,571	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	168,061	12,349	218	18,411	199,039	8.00
9.00	00900	HOUSEKEEPING	476,451	45,066	82	82,561	604,160	9.00
10.00	01000	DIETARY	321,114	86,172	7,312	34,036	448,634	10.00
11.00	01100	CAFETERIA	441,895	33,115	17,765	65,864	558,639	11.00
13.00	01300	NURSING ADMINISTRATION	509,193	29,729	0	98,724	637,646	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	231,987	24,534	53,766	10,111	320,398	14.00
15.00	01500	PHARMACY	437,158	16,146	60,479	86,144	599,927	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	564,284	55,346	2,081	103,221	724,932	16.00
17.00	01700	SOCIAL SERVICE	44,312	4,098	0	8,866	57,276	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,227,310	200,318	22,689	429,449	2,879,766	30.00
44.00	04400	SKILLED NURSING FACILITY	815,152	110,281	0	161,647	1,087,080	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	786,055	122,973	150,391	129,610	1,189,029	50.00
53.00	05300	ANESTHESIOLOGY	21,615	11,746	49,371	0	82,732	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,902,253	92,600	742,178	218,036	2,955,067	54.00
60.00	06000	LABORATORY	1,931,938	47,136	46,390	192,592	2,218,056	60.00
65.00	06500	RESPIRATORY THERAPY	538,394	17,942	10,196	101,068	667,600	65.00
66.00	06600	PHYSICAL THERAPY	1,069,680	62,569	5,902	207,575	1,345,726	66.00
66.01	06601	PHYSICAL THERAPY SNF	362,864	0	0	0	362,864	66.01
68.00	06800	SPEECH PATHOLOGY	112,187	4,290	0	22,168	138,645	68.00
69.00	06900	ELECTROCARDIOLOGY	151,827	17,215	8,773	29,366	207,181	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	123,740	0	0	7,726	131,466	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	471,822	0	0	0	471,822	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,176,627	0	0	0	1,176,627	73.00
76.00	03020	OP PSYCH	222,985	21,478	0	17,330	261,793	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,900,869	113,653	115,244	325,840	2,455,606	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,612,846	2,217,988	1,646,442	2,919,925	31,576,105	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,882	0	0	8,882	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,404	27,330	219	310	31,263	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	31,616,250	2,254,200	1,646,661	2,920,235	31,616,250	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/17/2015 9:09 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,104,242					5.00
6.00	00600	MAINTENANCE & REPAIRS	30,890	137,471				6.00
7.00	00700	OPERATION OF PLANT	748,789	97,318	3,429,678			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	57,687	2,451	36,357	295,534		8.00
9.00	00900	HOUSEKEEPING	175,102	307	132,676	8,436	920,681	9.00
10.00	01000	DIETARY	130,026	3,443	253,690	1,143	0	10.00
11.00	01100	CAFETERIA	161,909	0	97,489	2,070	8,523	11.00
13.00	01300	NURSING ADMINISTRATION	184,807	56	87,522	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	92,860	2,333	72,229	968	5,821	14.00
15.00	01500	PHARMACY	173,875	258	47,534	0	11,849	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	210,105	1,104	162,939	0	13,720	16.00
17.00	01700	SOCIAL SERVICE	16,600	0	12,065	0	1,663	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	834,634	7,920	589,738	121,575	257,351	30.00
44.00	04400	SKILLED NURSING FACILITY	315,065	3,345	324,668	99,699	110,590	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	344,613	1,984	362,034	18,412	91,881	50.00
53.00	05300	ANESTHESIOLOGY	23,978	272	34,581	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	856,456	880	272,615	9,029	56,126	54.00
60.00	06000	LABORATORY	642,853	1,404	138,769	740	61,323	60.00
65.00	06500	RESPIRATORY THERAPY	193,489	1,076	52,820	562	16,214	65.00
66.00	06600	PHYSICAL THERAPY	390,028	1,090	184,205	8,791	41,159	66.00
66.01	06601	PHYSICAL THERAPY SNF	105,168	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	40,183	84	12,630	0	6,236	68.00
69.00	06900	ELECTROCARDIOLOGY	60,047	398	50,682	0	6,028	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,102	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	136,747	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	341,018	0	0	0	0	73.00
76.00	03020	OP PSYCH	75,875	126	63,231	0	7,276	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	711,701	3,576	334,595	21,758	210,370	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)	7,092,607	129,425	3,323,069	293,183	906,130	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,574	140	26,148	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,061	7,906	80,461	2,351	14,551	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,104,242	137,471	3,429,678	295,534	920,681	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I Date/Time Prepared: 2/17/2015 9:09 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	836,936					10.00
11.00	01100	CAFETERIA	0	828,630				11.00
13.00	01300	NURSING ADMINISTRATION	0	26,046	936,077			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,174	27,305	530,088		14.00
15.00	01500	PHARMACY	0	24,898	0	0	858,341	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	56,823	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,503	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	539,363	182,481	389,772	12,592	0	30.00
44.00	04400	SKILLED NURSING FACILITY	297,573	78,574	167,825	4,312	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	41,088	87,777	21,865	283	50.00
53.00	05300	ANESTHESIOLOGY	0	9,381	0	6,238	540	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	80,039	0	38,815	0	54.00
60.00	06000	LABORATORY	0	80,039	0	210,348	63	60.00
65.00	06500	RESPIRATORY THERAPY	0	37,961	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	62,325	0	1,715	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0	5,799	0	232	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,213	4,374	1,445	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	62,789	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	151,101	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	857,455	73.00
76.00	03020	OP PSYCH	0	6,967	14,881	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	114,200	243,907	18,411	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)	836,936	828,511	935,841	529,863	858,341	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	119	236	225	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	836,936	828,630	936,077	530,088	858,341	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/17/2015 9:09 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,169,623					16.00
17.00	01700	SOCIAL SERVICE	0	91,107				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	290,061	75,213	6,180,466	0	6,180,466	30.00
44.00	04400	SKILLED NURSING FACILITY	33,001	15,894	2,537,626	0	2,537,626	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	89,971	0	2,248,937	0	2,248,937	50.00
53.00	05300	ANESTHESIOLOGY	0	0	157,722	0	157,722	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	199,743	0	4,468,770	0	4,468,770	54.00
60.00	06000	LABORATORY	66,002	0	3,419,597	0	3,419,597	60.00
65.00	06500	RESPIRATORY THERAPY	15,979	0	985,701	0	985,701	65.00
66.00	06600	PHYSICAL THERAPY	21,885	0	2,056,924	0	2,056,924	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	468,032	0	468,032	66.01
68.00	06800	SPEECH PATHOLOGY	0	0	203,809	0	203,809	68.00
69.00	06900	ELECTROCARDIOLOGY	21,885	0	362,253	0	362,253	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	232,357	0	232,357	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	759,670	0	759,670	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,375,100	0	2,375,100	73.00
76.00	03020	OP PSYCH	0	0	430,149	0	430,149	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	429,706	0	4,543,830	0	4,543,830	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,168,233	91,107	31,430,943	0	31,430,943	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	37,744	0	37,744	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,390	0	147,563	0	147,563	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,169,623	91,107	31,616,250	0	31,616,250	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/17/2015 9:09 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	5,688	0	5,688	5,688	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	62,975	366,837	312,587	742,399	788	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	106,581	0	106,581	0	6.00
7.00	00700	OPERATION OF PLANT	0	610,126	41,018	651,144	321	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,349	218	12,567	36	8.00
9.00	00900	HOUSEKEEPING	0	45,066	82	45,148	161	9.00
10.00	01000	DIETARY	0	86,172	7,312	93,484	66	10.00
11.00	01100	CAFETERIA	0	33,115	17,765	50,880	128	11.00
13.00	01300	NURSING ADMINISTRATION	0	29,729	0	29,729	192	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	24,534	53,766	78,300	20	14.00
15.00	01500	PHARMACY	0	16,146	60,479	76,625	168	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	55,346	2,081	57,427	201	16.00
17.00	01700	SOCIAL SERVICE	0	4,098	0	4,098	17	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,446	200,318	22,689	229,453	839	30.00
44.00	04400	SKILLED NURSING FACILITY	4,841	110,281	0	115,122	315	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	122,973	150,391	273,364	252	50.00
53.00	05300	ANESTHESIOLOGY	0	11,746	49,371	61,117	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	74,544	92,600	742,178	909,322	424	54.00
60.00	06000	LABORATORY	0	47,136	46,390	93,526	375	60.00
65.00	06500	RESPIRATORY THERAPY	1,308	17,942	10,196	29,446	197	65.00
66.00	06600	PHYSICAL THERAPY	0	62,569	5,902	68,471	404	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0	4,290	0	4,290	43	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,215	8,773	25,988	57	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,128	0	0	2,128	15	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	03020	OP PSYCH	0	21,478	0	21,478	34	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	113,653	115,244	228,897	634	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)	152,242	2,217,988	1,646,442	4,016,672	5,687	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,882	0	8,882	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	27,330	219	27,549	1	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	152,242	2,254,200	1,646,661	4,053,103	5,688	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/17/2015 9:09 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	743,187					5.00
6.00	00600	MAINTENANCE & REPAIRS	3,231	109,812				6.00
7.00	00700	OPERATION OF PLANT	78,331	77,742	807,538			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,035	1,958	8,560	29,156		8.00
9.00	00900	HOUSEKEEPING	18,318	245	31,239	832	95,943	9.00
10.00	01000	DIETARY	13,602	2,750	59,733	113	0	10.00
11.00	01100	CAFETERIA	16,937	0	22,954	204	888	11.00
13.00	01300	NURSING ADMINISTRATION	19,333	45	20,608	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,714	1,863	17,007	95	607	14.00
15.00	01500	PHARMACY	18,189	206	11,192	0	1,235	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,979	881	38,365	0	1,430	16.00
17.00	01700	SOCIAL SERVICE	1,737	0	2,841	0	173	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	87,312	6,327	138,858	11,995	26,819	30.00
44.00	04400	SKILLED NURSING FACILITY	32,959	2,672	76,445	9,836	11,524	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,050	1,584	85,243	1,816	9,575	50.00
53.00	05300	ANESTHESIOLOGY	2,508	218	8,142	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	89,602	703	64,189	891	5,849	54.00
60.00	06000	LABORATORY	67,249	1,121	32,674	73	6,390	60.00
65.00	06500	RESPIRATORY THERAPY	20,241	859	12,437	55	1,690	65.00
66.00	06600	PHYSICAL THERAPY	40,801	870	43,372	867	4,289	66.00
66.01	06601	PHYSICAL THERAPY SNF	11,002	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	4,204	67	2,974	0	650	68.00
69.00	06900	ELECTROCARDIOLOGY	6,282	318	11,933	0	628	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,986	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,305	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,674	0	0	0	0	73.00
76.00	03020	OP PSYCH	7,937	100	14,888	0	758	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	74,452	2,856	78,782	2,147	21,922	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)	741,970	103,385	782,436	28,924	94,427	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	269	112	6,157	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	948	6,315	18,945	232	1,516	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	743,187	109,812	807,538	29,156	95,943	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/17/2015 9:09 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	169,748					10.00
11.00	01100	CAFETERIA	0	91,991				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,892	72,799			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	907	2,124	110,637		14.00
15.00	01500	PHARMACY	0	2,764	0	0	110,379	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,308	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	389	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	109,394	20,259	30,313	2,628	0	30.00
44.00	04400	SKILLED NURSING FACILITY	60,354	8,723	13,052	900	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,561	6,826	4,564	36	50.00
53.00	05300	ANESTHESIOLOGY	0	1,041	0	1,302	69	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,886	0	8,101	0	54.00
60.00	06000	LABORATORY	0	8,886	0	43,902	8	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,214	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,919	0	358	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0	644	0	48	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,134	340	302	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	13,105	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,537	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	110,266	73.00
76.00	03020	OP PSYCH	0	773	1,157	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	12,678	18,969	3,843	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)	169,748	91,978	72,781	110,590	110,379	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	13	18	47	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	169,748	91,991	72,799	110,637	110,379	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/17/2015 9:09 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	126,591					16.00
17.00	01700	SOCIAL SERVICE	0	9,255				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,394	7,640	703,231	0	703,231	30.00
44.00	04400	SKILLED NURSING FACILITY	3,572	1,615	337,089	0	337,089	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,738	0	433,609	0	433,609	50.00
53.00	05300	ANESTHESIOLOGY	0	0	74,397	0	74,397	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,619	0	1,109,586	0	1,109,586	54.00
60.00	06000	LABORATORY	7,144	0	261,348	0	261,348	60.00
65.00	06500	RESPIRATORY THERAPY	1,729	0	70,868	0	70,868	65.00
66.00	06600	PHYSICAL THERAPY	2,369	0	168,720	0	168,720	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	11,002	0	11,002	66.01
68.00	06800	SPEECH PATHOLOGY	0	0	12,920	0	12,920	68.00
69.00	06900	ELECTROCARDIOLOGY	2,369	0	49,351	0	49,351	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	19,234	0	19,234	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	45,842	0	45,842	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	145,940	0	145,940	73.00
76.00	03020	OP PSYCH	0	0	47,125	0	47,125	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	46,507	0	491,687	0	491,687	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)	126,441	9,255	3,981,949	0	3,981,949	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	15,420	0	15,420	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	150	0	55,734	0	55,734	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	126,591	9,255	4,053,103	0	4,053,103	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/17/2015 9:09 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	164,464					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,633,648				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	415	0	13,504,068			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,764	310,117	1,871,261	-7,104,242	24,512,008	5.00
6.00	00600	MAINTENANCE & REPAIRS	7,776	0	0	0	106,581	6.00
7.00	00700	OPERATION OF PLANT	44,514	40,694	762,649	0	2,583,571	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	901	216	85,139	0	199,039	8.00
9.00	00900	HOUSEKEEPING	3,288	81	381,786	0	604,160	9.00
10.00	01000	DIETARY	6,287	7,254	157,392	0	448,634	10.00
11.00	01100	CAFETERIA	2,416	17,625	304,575	0	558,639	11.00
13.00	01300	NURSING ADMINISTRATION	2,169	0	456,527	0	637,646	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,790	53,341	46,758	0	320,398	14.00
15.00	01500	PHARMACY	1,178	60,001	398,357	0	599,927	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,038	2,065	477,327	0	724,932	16.00
17.00	01700	SOCIAL SERVICE	299	0	40,997	0	57,276	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,615	22,510	1,985,923	0	2,879,766	30.00
44.00	04400	SKILLED NURSING FACILITY	8,046	0	747,505	0	1,087,080	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,972	149,202	599,356	0	1,189,029	50.00
53.00	05300	ANESTHESIOLOGY	857	48,981	0	0	82,732	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,756	736,314	1,008,264	0	2,955,067	54.00
60.00	06000	LABORATORY	3,439	46,023	890,603	0	2,218,056	60.00
65.00	06500	RESPIRATORY THERAPY	1,309	10,115	467,369	0	667,600	65.00
66.00	06600	PHYSICAL THERAPY	4,565	5,855	959,891	0	1,345,726	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	362,864	66.01
68.00	06800	SPEECH PATHOLOGY	313	0	102,513	0	138,645	68.00
69.00	06900	ELECTROCARDIOLOGY	1,256	8,704	135,797	0	207,181	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	35,727	0	131,466	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	471,822	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,176,627	73.00
76.00	03020	OP PSYCH	1,567	0	80,137	0	261,793	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,292	114,333	1,506,783	0	2,455,606	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	161,822	1,633,431	13,502,636	-7,104,242	24,471,863	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	648	0	0	0	8,882	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,994	217	1,432	0	31,263	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,254,200	1,646,661	2,920,235		7,104,242	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.706343	1.007966	0.216249		0.289827	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,688		743,187	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000421		0.030319	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/17/2015 9:09 am

		Cost Center Description	MAINTENANCE & REPAIRS (HOURS OF SERVICE)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	19,683					6.00
7.00	00700	OPERATION OF PLANT	13,934	84,995				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	351	901	327,029			8.00
9.00	00900	HOUSEKEEPING	44	3,288	9,335	4,429		9.00
10.00	01000	DIETARY	493	6,287	1,265	0	32,977	10.00
11.00	01100	CAFETERIA	0	2,416	2,291	41	0	11.00
13.00	01300	NURSING ADMINISTRATION	8	2,169	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	334	1,790	1,071	28	0	14.00
15.00	01500	PHARMACY	37	1,178	0	57	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	158	4,038	0	66	0	16.00
17.00	01700	SOCIAL SERVICE	0	299	0	8	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,134	14,615	134,530	1,238	21,252	30.00
44.00	04400	SKILLED NURSING FACILITY	479	8,046	110,324	532	11,725	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	284	8,972	20,374	442	0	50.00
53.00	05300	ANESTHESIOLOGY	39	857	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	126	6,756	9,991	270	0	54.00
60.00	06000	LABORATORY	201	3,439	819	295	0	60.00
65.00	06500	RESPIRATORY THERAPY	154	1,309	622	78	0	65.00
66.00	06600	PHYSICAL THERAPY	156	4,565	9,728	198	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	12	313	0	30	0	68.00
69.00	06900	ELECTROCARDIOLOGY	57	1,256	0	29	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	03020	OP PSYCH	18	1,567	0	35	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	512	8,292	24,077	1,012	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)	18,531	82,353	324,427	4,359	32,977	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20	648	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,132	1,994	2,602	70	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	137,471	3,429,678	295,534	920,681	836,936	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.984250	40.351527	0.903694	207.875593	25.379386	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	109,812	807,538	29,156	95,943	169,748	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.579028	9.501006	0.089154	21.662452	5.147466	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/17/2015 9:09 am

		Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	41,867					11.00
13.00	01300	NURSING ADMINISTRATION	1,316	206,514				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	413	6,024	1,310,137			14.00
15.00	01500	PHARMACY	1,258	0	0	1,176,627		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,871	0	0	0	3,367	16.00
17.00	01700	SOCIAL SERVICE	177	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,220	85,990	31,121	0	835	30.00
44.00	04400	SKILLED NURSING FACILITY	3,970	37,025	10,657	0	95	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,076	19,365	54,040	388	259	50.00
53.00	05300	ANESTHESIOLOGY	474	0	15,418	740	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,044	0	95,933	0	575	54.00
60.00	06000	LABORATORY	4,044	0	519,885	86	190	60.00
65.00	06500	RESPIRATORY THERAPY	1,918	0	0	0	46	65.00
66.00	06600	PHYSICAL THERAPY	3,149	0	4,238	0	63	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	293	0	574	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	516	965	3,571	0	63	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	155,187	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	373,454	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,175,413	0	73.00
76.00	03020	OP PSYCH	352	3,283	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,770	53,810	45,504	0	1,237	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)	41,861	206,462	1,309,582	1,176,627	3,363	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	6	52	555	0	4	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	828,630	936,077	530,088	858,341	1,169,623	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.791960	4.532753	0.404605	0.729493	347.378378	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	91,991	72,799	110,637	110,379	126,591	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.197220	0.352514	0.084447	0.093810	37.597565	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/17/2015 9:09 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)		
			17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	2,098		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	1,732		30.00
44.00	04400	SKILLED NURSING FACILITY	366		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
66.01	06601	PHYSICAL THERAPY SNF	0		66.01
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03020	OP PSYCH	0		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,098		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0		194.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	91,107		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	43.425643		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,255		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.411344		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/17/2015 9:09 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,180,466		6,180,466	0	6,180,466	30.00
44.00	04400	SKILLED NURSING FACILITY	2,537,626		2,537,626	0	2,537,626	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,248,937		2,248,937	0	2,248,937	50.00
53.00	05300	ANESTHESIOLOGY	157,722		157,722	0	157,722	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,468,770		4,468,770	0	4,468,770	54.00
60.00	06000	LABORATORY	3,419,597		3,419,597	0	3,419,597	60.00
65.00	06500	RESPIRATORY THERAPY	985,701	0	985,701	0	985,701	65.00
66.00	06600	PHYSICAL THERAPY	2,056,924	0	2,056,924	0	2,056,924	66.00
66.01	06601	PHYSICAL THERAPY SNF	468,032	0	468,032	0	468,032	66.01
68.00	06800	SPEECH PATHOLOGY	203,809	0	203,809	0	203,809	68.00
69.00	06900	ELECTROCARDIOLOGY	362,253		362,253	0	362,253	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	232,357		232,357	0	232,357	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	759,670		759,670	0	759,670	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,375,100		2,375,100	0	2,375,100	73.00
76.00	03020	OP PSYCH	430,149		430,149	0	430,149	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,543,830		4,543,830	0	4,543,830	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	311,245		311,245		311,245	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	31,742,188	0	31,742,188	0	31,742,188	200.00
201.00		Less Observation Beds	311,245		311,245		311,245	201.00
202.00		Total (see instructions)	31,430,943	0	31,430,943	0	31,430,943	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/17/2015 9:09 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	5,991,267		5,991,267			30.00
44.00	04400	SKILLED NURSING FACILITY	1,354,891		1,354,891			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	337,175	6,008,271	6,345,446	0.354417	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	85,489	482,822	568,311	0.277528	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,514,745	29,761,491	32,276,236	0.138454	0.000000	54.00
60.00	06000	LABORATORY	2,276,589	9,421,482	11,698,071	0.292321	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	331,407	1,695,902	2,027,309	0.486212	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	847,873	2,488,175	3,336,048	0.616575	0.000000	66.00
66.01	06601	PHYSICAL THERAPY SNF	1,844,742	0	1,844,742	0.253711	0.000000	66.01
68.00	06800	SPEECH PATHOLOGY	107,763	341,028	448,791	0.454129	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	343,775	1,739,311	2,083,086	0.173902	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,208,166	1,531,407	3,739,573	0.062135	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	124,404	769,477	893,881	0.849856	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,547,103	1,823,820	3,370,923	0.704584	0.000000	73.00
76.00	03020	OP PSYCH	0	170,684	170,684	2.520148	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	92,249	5,128,797	5,221,046	0.870291	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,885	403,329	408,214	0.762455	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	20,012,523	61,765,996	81,778,519			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	20,012,523	61,765,996	81,778,519			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/17/2015 9:09 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
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
66.01	06601	PHYSICAL THERAPY SNF	0.000000		66.01
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	OP PSYCH	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part II Date/Time Prepared: 2/17/2015 9:09 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	433,609	6,345,446	0.068334	128,041	8,750	50.00
53.00	05300	ANESTHESIOLOGY	74,397	568,311	0.130909	55,747	7,298	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,109,586	32,276,236	0.034378	1,692,720	58,192	54.00
60.00	06000	LABORATORY	261,348	11,698,071	0.022341	1,550,529	34,640	60.00
65.00	06500	RESPIRATORY THERAPY	70,868	2,027,309	0.034957	179,624	6,279	65.00
66.00	06600	PHYSICAL THERAPY	168,720	3,336,048	0.050575	226,263	11,443	66.00
66.01	06601	PHYSICAL THERAPY SNF	11,002	1,844,742	0.005964	70,842	423	66.01
68.00	06800	SPEECH PATHOLOGY	12,920	448,791	0.028788	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	49,351	2,083,086	0.023691	237,622	5,630	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,234	3,739,573	0.005143	1,192,597	6,134	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,842	893,881	0.051284	88,860	4,557	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	145,940	3,370,923	0.043294	706,330	30,580	73.00
76.00	03020	OP PSYCH	47,125	170,684	0.276095	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	491,687	5,221,046	0.094174	2,319	218	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	42,325	408,214	0.103683	4,885	506	92.00
200.00		Total (lines 50-199)	2,983,954	74,432,361		6,136,379	174,650	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/17/2015 9:09 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	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	03020	OP PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/17/2015 9:09 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,345,446	0.000000	0.000000	128,041	50.00
53.00	05300	ANESTHESIOLOGY	0	568,311	0.000000	0.000000	55,747	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,276,236	0.000000	0.000000	1,692,720	54.00
60.00	06000	LABORATORY	0	11,698,071	0.000000	0.000000	1,550,529	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,027,309	0.000000	0.000000	179,624	65.00
66.00	06600	PHYSICAL THERAPY	0	3,336,048	0.000000	0.000000	226,263	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	1,844,742	0.000000	0.000000	70,842	66.01
68.00	06800	SPEECH PATHOLOGY	0	448,791	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,083,086	0.000000	0.000000	237,622	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,739,573	0.000000	0.000000	1,192,597	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	893,881	0.000000	0.000000	88,860	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,370,923	0.000000	0.000000	706,330	73.00
76.00	03020	OP PSYCH	0	170,684	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	5,221,046	0.000000	0.000000	2,319	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	408,214	0.000000	0.000000	4,885	92.00
200.00		Total (lines 50-199)	0	74,432,361			6,136,379	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/17/2015 9:09 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
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0		66.01
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	OP PSYCH	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/17/2015 9:09 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	0.354417	0	2,770,984	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.277528	0	228,376	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.138454	0	11,582,675	0	0	54.00
60.00	06000	LABORATORY	0.292321	0	3,742,099	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.486212	0	664,189	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.616575	0	973,037	0	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0.253711	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0.454129	0	32,437	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.173902	0	809,945	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.062135	0	589,257	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.849856	0	532,862	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.704584	0	1,009,178	2,529	0	73.00
76.00	03020	OP PSYCH	2.520148	0	150,877	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.870291	0	1,602,225	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.762455	0	139,595	0	0	92.00
200.00		Subtotal (see instructions)		0	24,827,736	2,529	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	24,827,736	2,529	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/17/2015 9:09 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	982,084	0		50.00
53.00	05300	ANESTHESIOLOGY	63,381	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,603,668	0		54.00
60.00	06000	LABORATORY	1,093,894	0		60.00
65.00	06500	RESPIRATORY THERAPY	322,937	0		65.00
66.00	06600	PHYSICAL THERAPY	599,950	0		66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0		66.01
68.00	06800	SPEECH PATHOLOGY	14,731	0		68.00
69.00	06900	ELECTROCARDIOLOGY	140,851	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,613	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	452,856	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	711,051	1,782		73.00
76.00	03020	OP PSYCH	380,232	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,394,402	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	106,435	0		92.00
200.00		Subtotal (see instructions)	7,903,085	1,782		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	7,903,085	1,782		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141339 | Component CCN: 14Z339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/17/2015 9:09 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	0.354417	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.277528	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.138454	0	0	0	0	54.00
60.00	06000	LABORATORY	0.292321	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.486212	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.616575	0	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0.253711	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0.454129	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.173902	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.062135	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.849856	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.704584	0	0	0	0	73.00
76.00	03020	OP PSYCH	2.520148	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.870291	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.762455	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141339 | Component CCN: 14Z339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V | Date/Time Prepared: 2/17/2015 9:09 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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0		66.01
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	OP PSYCH	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141339 | Component CCN: 145539 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/17/2015 9:09 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	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	03020	OP PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141339 | Component CCN: 145539 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/17/2015 9:09 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,345,446	0.000000	0.000000	8,118	50.00
53.00	05300	ANESTHESIOLOGY	0	568,311	0.000000	0.000000	7,252	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,276,236	0.000000	0.000000	126,101	54.00
60.00	06000	LABORATORY	0	11,698,071	0.000000	0.000000	261,164	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,027,309	0.000000	0.000000	20,308	65.00
66.00	06600	PHYSICAL THERAPY	0	3,336,048	0.000000	0.000000	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	1,844,742	0.000000	0.000000	1,591,323	66.01
68.00	06800	SPEECH PATHOLOGY	0	448,791	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,083,086	0.000000	0.000000	12,219	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,739,573	0.000000	0.000000	282,717	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	893,881	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,370,923	0.000000	0.000000	298,983	73.00
76.00	03020	OP PSYCH	0	170,684	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	5,221,046	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	408,214	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	74,432,361			2,608,185	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141339 | Component CCN: 145539 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/17/2015 9:09 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0		66.01
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	OP PSYCH	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/17/2015 9:09 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)	5,472	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,403	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,138	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	208	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)	624	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	59	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)	178	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,099	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)	201	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)	602	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)	6,180,466	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)	7,938	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)	23,948	25.00
26.00	Total swing-bed cost (see instructions)	1,009,078	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,171,388	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,171,388	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)	1,174.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,639,806	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)	3,639,806	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/17/2015 9:09 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)						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)	1,687,638	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,327,444	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)	236,077	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	707,055	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	943,132	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)	265	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,174.51	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	311,245	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/17/2015 9:09 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	703,231	5,171,388	0.135985	311,245	42,325	90.00
91.00	Nursing School cost	0	5,171,388	0.000000	311,245	0	91.00
92.00	Allied health cost	0	5,171,388	0.000000	311,245	0	92.00
93.00	All other Medical Education	0	5,171,388	0.000000	311,245	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141339	Period: From 10/01/2013	Worksheet D-1
Component CCN: 145539	To 09/30/2014	Date/Time Prepared: 2/17/2015 9:09 am
Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,934	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,934	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)	3,934	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,849	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,537,626	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,537,626	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,537,626	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1

Component CCN: 145539 | Date/Time Prepared: 2/17/2015 9:09 am

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	2,537,626	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	645.05	71.00
72.00	Program routine service cost (line 9 x line 71)	1,837,747	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,837,747	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,837,747	83.00
84.00	Program inpatient ancillary services (see instructions)	742,654	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,580,401	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1

Component CCN: 145539 | Date/Time Prepared: 2/17/2015 9:09 am

Title XVIII | Skilled Nursing Facility | PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/17/2015 9:09 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		3,873,335		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.354417	128,041	45,380	50.00
53.00	05300	ANESTHESIOLOGY	0.277528	55,747	15,471	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.138454	1,692,720	234,364	54.00
60.00	06000	LABORATORY	0.292321	1,550,529	453,252	60.00
65.00	06500	RESPIRATORY THERAPY	0.486212	179,624	87,335	65.00
66.00	06600	PHYSICAL THERAPY	0.616575	226,263	139,508	66.00
66.01	06601	PHYSICAL THERAPY SNF	0.253711	70,842	17,973	66.01
68.00	06800	SPEECH PATHOLOGY	0.454129	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.173902	237,622	41,323	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.062135	1,192,597	74,102	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.849856	88,860	75,518	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.704584	706,330	497,669	73.00
76.00	03020	OP PSYCH	2.520148	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.870291	2,319	2,018	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.762455	4,885	3,725	92.00
200.00		Total (sum of lines 50-94 and 96-98)		6,136,379	1,687,638	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		6,136,379		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3

Component CCN: 14Z339 | Date/Time Prepared: 2/17/2015 9:09 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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.354417	2,147	761	50.00
53.00	05300	ANESTHESIOLOGY	0.277528	1,728	480	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.138454	54,247	7,511	54.00
60.00	06000	LABORATORY	0.292321	142,322	41,604	60.00
65.00	06500	RESPIRATORY THERAPY	0.486212	25,448	12,373	65.00
66.00	06600	PHYSICAL THERAPY	0.616575	160,006	98,656	66.00
66.01	06601	PHYSICAL THERAPY SNF	0.253711	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0.454129	19,605	8,903	68.00
69.00	06900	ELECTROCARDIOLOGY	0.173902	6,716	1,168	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.062135	176,000	10,936	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.849856	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.704584	155,617	109,645	73.00
76.00	03020	OP PSYCH	2.520148	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.870291	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.762455	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		743,836	292,037	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)		743,836		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3

Component CCN: 145539 | Date/Time Prepared: 2/17/2015 9:09 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.354417	8,118	2,877	50.00
53.00	05300	ANESTHESIOLOGY	0.277528	7,252	2,013	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.138454	126,101	17,459	54.00
60.00	06000	LABORATORY	0.292321	261,164	76,344	60.00
65.00	06500	RESPIRATORY THERAPY	0.486212	20,308	9,874	65.00
66.00	06600	PHYSICAL THERAPY	0.616575	0	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0.253711	1,591,323	403,736	66.01
68.00	06800	SPEECH PATHOLOGY	0.454129	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.173902	12,219	2,125	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.062135	282,717	17,567	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.849856	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.704584	298,983	210,659	73.00
76.00	03020	OP PSYCH	2.520148	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.870291	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.762455	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,608,185	742,654	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		2,608,185		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141339	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part B Date/Time Prepared: 2/17/2015 9:09 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,904,867	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)	7,904,867	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)	7,983,916	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)	38,523	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4,255,854	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)	3,689,539	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)	3,689,539	30.00
31.00	Primary payer payments	169	31.00
32.00	Subtotal (line 30 minus line 31)	3,689,370	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)	1,050,258	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	798,196	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	936,036	36.00
37.00	Subtotal (see instructions)	4,487,566	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)	4,487,566	40.00
40.01	Sequestration adjustment (see instructions)	89,751	40.01
41.00	Interim payments	3,794,167	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	603,648	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: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 2/17/2015 9:09 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		4,602,867		4,345,879	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	05/30/2014	83,200		0	3.01
3.02		09/29/2014	137,065		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	05/30/2014	96,459	3.50
3.51			0	09/29/2014	455,253	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)		220,265		-551,712	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)		4,823,132		3,794,167	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		603,648	6.01
6.02	SETTLEMENT TO PROGRAM		99,294		0	6.02
7.00	Total Medicare program liability (see instructions)		4,723,838		4,397,815	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 2/17/2015 9:09 am

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

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,124,890		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	09/29/2014	52,057		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		52,057		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)		1,176,947		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		26,830		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,203,777		0	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141339 | Component CCN: 145539 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 2/17/2015 9:09 am

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,018,293		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,018,293		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,018,293		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141339	Period: From 10/01/2013 To 09/30/2014	Worksheet E-1 Part II Date/Time Prepared: 2/17/2015 9:09 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	1,174	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	3,099	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	4,138	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	81,778,519	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	3,615,394	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	40,300	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	39,639	8.00
9.00	Sequestration adjustment amount (see instructions)	793	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	38,846	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)	38,846	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141339 | Component CCN: 14Z339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E-2 | Date/Time Prepared: 2/17/2015 9:09 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)	952,563	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)	294,957	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	803	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)	1,247,520	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,247,520	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)	1,247,520	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	19,176	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)	1,228,344	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)	1,228,344	0	19.00
19.01	Sequestration adjustment (see instructions)	24,567	0	19.01
20.00	Interim payments	1,176,947	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	26,830	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141339	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part V Date/Time Prepared: 2/17/2015 9:09 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,327,444	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	5,327,444	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,380,718	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)	5,380,718	19.00
20.00	Deductibles (exclude professional component)	615,748	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,764,970	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	4,764,970	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	72,728	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	55,273	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	48,263	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,820,243	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)	4,820,243	30.00
30.01	Sequestration adjustment (see instructions)	96,405	30.01
31.00	Interim payments	4,823,132	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	-99,294	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141339 Component CCN: 145539	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part VI Date/Time Prepared: 2/17/2015 9:09 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,202,999	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,202,999	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	163,924	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	1,039,075	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	1,039,075	15.00
15.01	Sequestration adjustment (see instructions)	20,782	15.01
16.00	Interim payments	1,018,293	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G | Date/Time Prepared: 2/17/2015 9:09 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	13,653,086	0	0	0	1.00
2.00	Temporary investments	1,566,477	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,290,727	0	0	0	4.00
5.00	Other receivable	75,116	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,600,198	0	0	0	6.00
7.00	Inventory	647,537	0	0	0	7.00
8.00	Prepaid expenses	253,759	0	0	0	8.00
9.00	Other current assets	592,739	0	0	0	9.00
10.00	Due from other funds	63,948	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	22,543,191	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	737,345	0	0	0	12.00
13.00	Land improvements	3,419,907	0	0	0	13.00
14.00	Accumulated depreciation	-1,269,539	0	0	0	14.00
15.00	Buildings	25,009,750	0	0	0	15.00
16.00	Accumulated depreciation	-8,123,843	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	21,380,211	0	0	0	23.00
24.00	Accumulated depreciation	-18,064,949	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	1,824,599	0	0	0	27.00
28.00	Accumulated depreciation	-233,343	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)	24,680,138	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,149,178	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	260,336	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,409,514	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	50,632,843	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	884,586	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,960,487	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	74,476	0	0	0	40.00
41.00	Deferred income	486,150	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	26,439	0	0	0	43.00
44.00	Other current liabilities	1,897,777	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,329,915	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	18,006,529	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	446,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	18,452,529	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	23,782,444	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	26,850,399				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)	26,850,399	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	50,632,843	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-1 | Date/Time Prepared: 2/17/2015 9:09 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		25,186,977		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,663,422				2.00
3.00	Total (sum of line 1 and line 2)		26,850,399		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)		26,850,399		0		11.00
12.00	Deductions (debit adjustments) (specify)	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)		26,850,399		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	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/17/2015 9:09 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,640,266		5,640,266	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	180,276		180,276	5.00
6.00	Swing bed - NF	23,406		23,406	6.00
7.00	SKILLED NURSING FACILITY	571,907		571,907	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,415,855		6,415,855	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,415,855		6,415,855	17.00
18.00	Ancillary services	11,021,907	62,844,738	73,866,645	18.00
19.00	Outpatient services	207,819	12,470,505	12,678,324	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)	17,645,581	75,315,243	92,960,824	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		36,359,474		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		36,359,474		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141339 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-3 | Date/Time Prepared: 2/17/2015 9:09 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	92,960,824	1.00
2.00	Less contractual allowances and discounts on patients' accounts	58,113,079	2.00
3.00	Net patient revenues (line 1 minus line 2)	34,847,745	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	36,359,474	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,511,729	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	56,475	6.00
7.00	Income from investments	228,100	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	1,544	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	179,507	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	10,512	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MEANINGFUL USE INCOME	89,192	24.00
24.01	HOSPITAL ACCESS IMPROVEMENT	2,207,387	24.01
24.02	MISCELLANEOUS INCOME	80,901	24.02
24.03	GAIN ON DISPOSAL OF ASSETS	112,074	24.03
24.04	GAIN ON DEFERRED COMPENSATION	209,459	24.04
25.00	Total other income (sum of lines 6-24)	3,175,151	25.00
26.00	Total (line 5 plus line 25)	1,663,422	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,663,422	29.00