

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: 140100  
 Period: From 07/01/2011 To 06/30/2012  
 Worksheet 5  
 Parts I-III  
 Date/Time Prepared: 11/23/2012 3:42 pm

**PART I - COST REPORT STATUS**

Provider use only  
 1.  Electronically filed cost report  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.  
 Date: 11/23/2012 Time: 3:42 pm

Contractor use only  
 5.  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.  Initial Report for this Provider CCN  
 9.  Final Report for this Provider CCN  
 10. NPR Date:  
 11. Contractor's Vendor Code: 4  
 12.  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 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 MIDWESTERN REGIONAL MEDICAL CENTER for the cost reporting period beginning 07/01/2011 and ending 06/30/2012 and to the best of my knowledge and belief, it is a true, correct and complete statement 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 identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)

Title \_\_\_\_\_

Date \_\_\_\_\_

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	2,454	52,522	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	2,454	52,522	0	0	200.00

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

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**Encryption Information**  
 ECR: Date: 11/23/2012 Time: 3:42 pm  
 7uG.Iuu:Qv1NdsgqC2huxnfWdATZ80  
 kLoyw0ZV57svunj1Pmb4uxSqyOZW4N  
 atvv024bsj0NAkha  
 PI: Date: 11/23/2012 Time: 3:42 pm  
 PKKmfu6YXnoAjxgG806Qt96kMcSej0  
 Ehpky0DvkbTmz5ziDaaZFm07RCqgtD  
 pQRHLGY1aw0sDjfd

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)  
 Title \_\_\_\_\_  
 Date \_\_\_\_\_

	Title v 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	2,454	52,522	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	2,454	52,522	0	0	200.00

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

		1.00	2.00	3.00	4.00				1.00	2.00	
<b>Hospital and Hospital Health Care Complex Address:</b>											
1.00	Street: 2501 EMMAUS AVENUE	PO Box:		Zip Code: 60099	County: LAKE				1.00	2.00	
2.00	City: ZION	State: IL									
		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		
<b>Hospital and Hospital-Based Component Identification:</b>											
3.00	Hospital	MIDWESTERN REGIONAL MEDICAL CENTER	140100	29404	1	07/01/1967	N	P	O	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									7.00	
8.00	Swing Beds - NF									8.00	
9.00	Hospital-Based SNF									9.00	
10.00	Hospital-Based NF									10.00	
11.00	Hospital-Based OLTC									11.00	
12.00	Hospital-Based HHA									12.00	
13.00	Separately Certified ASC									13.00	
14.00	Hospital-Based Hospice									14.00	
15.00	Hospital-Based Health Clinic - RHC									15.00	
16.00	Hospital-Based Health Clinic - FQHC									16.00	
17.00	Hospital-Based (CMHC) 1									17.00	
18.00	Renal Dialysis									18.00	
19.00	Other									19.00	
							From:	To:			
20.00	Cost Reporting Period (mm/dd/yyyy)						1.00	2.00			
21.00	Type of Control (see instructions)						07/01/2011	06/30/2012	20.00		
							4			21.00	
<b>Inpatient PPS Information</b>											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00		
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.					0	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 days	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 days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible 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 days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		25.00		
						Urban/Rural S	Date of Geogr				
						1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.					1			26.00		
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			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		

		Beginning:	Ending:			
		1.00	2.00			
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
		V	XVIII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS) Capital</b>						
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 the special exceptions payment pursuant to 42 CFR Section §412.348(g)? 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
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00		0.00	61.00
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
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
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
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		
<b>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.</b>						
64.00	If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.		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

		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	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
<b>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</b>							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
<b>Inpatient Psychiatric Facility PPS</b>					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00
				1.00	
<b>Long Term Care Hospital PPS</b>					
80.00	Are you a long term care hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. LTCHs can only exist as independent/freestanding facilities. An independent or freestanding facility may exist as an unrelated hospital within a hospital, it must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22(e.)		N		80.00
<b>TEFRA Providers</b>					
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.		N		86.00
		V	XIX		
		1.00	2.00		
<b>Title V or XIX Inpatient Services</b>					
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		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		97.00
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			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)				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)				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.				109.00
				1.00	2.00
					3.00
<b>Miscellaneous Cost Reporting Information</b>					
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

		1.00	2.00	3.00			
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00		
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00		
		Premiums		Losses		Insurance	
		1.00	2.00	3.00			
118.01	Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self insurance paid in column 3.	3,241,753	0	0		118.01	
		1.00		2.00			
118.02	Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPs calculation on worksheet E, Part B, line 8.	N		N		120.00	
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N				121.00	
<b>Transplant Center Information</b>							
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	
<b>All Providers</b>							
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		14H130		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: CANCER TREATMENT CENTERS OF AMERICA	Contractor's Name: NGS		Contractor's Number: 00131		141.00	
142.00	Street: 1336 BASSWOOD ROAD	PO Box: 6775 W WA				142.00	
143.00	City: SCHAUMBURG, IL 60173	State: IL		Zip Code: 53214		143.00	
		1.00		2.00			
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet S-2  
Part I  
Date/Time Prepared:  
11/23/2012 3:41 pm

		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
<b>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)</b>							
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		
<b>Multicampus</b>							
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
					1.00		
<b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b>							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	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)						0168.00
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)						0.00169.00

		Y/N	Date	
		1.00	2.00	
<b>General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.</b>				
<b>COMPLETED BY ALL HOSPITALS</b>				
<b>Provider Organization and Operation</b>				
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
<b>Financial Data and Reports</b>				
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.	Y		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
<b>Approved Educational Activities</b>				
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		
<b>Bad Debts</b>				
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
<b>Bed Complement</b>				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		Y	15.00
		<b>Part A</b>		
		Description	Y/N	Date
		0	1.00	2.00
<b>PS&amp;R Data</b>				
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	09/14/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

	Description	Part A			
		Y/N	Date		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00	2.00	21.00
			N		
					1.00
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
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		Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		Y		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
<b>Interest Expense</b>					
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		N		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
<b>Purchased Services</b>					
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
<b>Provider Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N		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	
<b>Home Office Costs</b>					
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
<b>Cost Report Preparer Contact Information</b>					
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.	COREY		BOELTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	612-376-4500		COREY.BOELTER@CLIFTONLARSONALLEN.COM	43.00

		Part B		
		Y/N	Date	
		3.00	4.00	
<b>PS&amp;R Data</b>				
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	09/14/2012	16.00
17.00	was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		3.00		
<b>Cost Report Preparer Contact Information</b>				
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.	PRINCIPAL		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

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	50	18,270	0.00		1.00
2.00 HMO						2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						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)		50	18,270	0.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,196	0.00		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	12	4,212	0.00		11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		68	24,678	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		68				27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title v	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,550	19	12,035		1.00
2.00 HMO		0	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,550	19	12,035		7.00
8.00 INTENSIVE CARE UNIT	0	135	5	639		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT	0	82	0	459		11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0	1,767	24	13,133		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		2	704		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid workers	Title v	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, observation Bed and Hospice days)				0	225	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						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	1,034.50	0.00	0	225	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	1,034.50	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	4	1,433		1.00
2.00 HMO				2.00
3.00 HMO IPF				3.00
4.00 HMO IRF				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)	4	1,433		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>PART II - WAGE DATA</b>						
<b>SALARIES</b>						
1.00	Total salaries (see instructions)	200.00	63,264,510	0	63,264,510	2,151,752.53 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00 4.01
5.00	Physician-Part B		0	0	0	0.00 5.00
6.00	Non-physician-Part B		0	0	0	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00 7.01
8.00	Home office personnel		0	0	0	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00 9.00
10.00	Excluded area salaries (see instructions)		4,876,661	845,451	5,722,112	243,064.92 10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>						
11.00	Contract labor (see instructions)		2,406,174	0	2,406,174	30,479.35 11.00
12.00	Contract management and administrative services		0	0	0	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		331,264	0	331,264	4,660.00 13.00
14.00	Home office salaries & wage-related costs		31,233,931	0	31,233,931	257,724.00 14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00 15.00
16.00	Home office and Contract Physicians Part A - Administrative		0	0	0	0.00 16.00
<b>AGE-RELATED COSTS</b>						
17.00	wage-related costs (core) wkst S-3, Part IV line 24		18,345,751	0	18,345,751	
18.00	wage-related costs (other)wkst S-3, Part IV line 25		0	0	0	
19.00	Excluded areas		2,336,269	0	2,336,269	
20.00	Non-physician anesthetist Part A		0	0	0	
21.00	Non-physician anesthetist Part B		0	0	0	
22.00	Physician Part A - Administrative		0	0	0	
22.01	Physician Part A - Teaching		0	0	0	
23.00	Physician Part B		0	0	0	
24.00	wage-related costs (RHC/FQHC)		0	0	0	
25.00	Interns & residents (in an approved program)		0	0	0	
<b>OVERHEAD COSTS - DIRECT SALARIES</b>						
26.00	Employee Benefits	4.00	9,081,695	-8,009,371	1,072,324	22,348.75 26.00
27.00	Administrative & General	5.00	5,226,959	1,433,066	6,660,025	207,801.38 27.00
28.00	Administrative & General under contract (see inst.)		453,198	0	453,198	1,351.00 28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00 29.00
30.00	Operation of Plant	7.00	1,484,647	191,798	1,676,445	64,882.85 30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00 31.00
32.00	Housekeeping	9.00	1,179,798	152,415	1,332,213	85,596.58 32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00 33.00
34.00	Dietary	10.00	1,644,760	-1,407,086	237,674	15,011.66 34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00 35.00
36.00	Cafeteria	11.00	0	1,619,568	1,619,568	102,293.12 36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00 37.00
38.00	Nursing Administration	13.00	1,122,068	144,957	1,267,025	31,341.95 38.00
39.00	Central Services and Supply	14.00	301,910	39,003	340,913	18,870.95 39.00
40.00	Pharmacy	15.00	2,042,548	263,872	2,306,420	66,540.17 40.00
41.00	Medical Records & Medical Records Library	16.00	1,731,485	223,686	1,955,171	81,928.71 41.00
42.00	Social Service	17.00	1,071,648	174,820	1,246,468	42,914.61 42.00
43.00	Other General Service	18.00	5,102,836	659,222	5,762,058	173,823.15 43.00

		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
<b>PART II - WAGE DATA</b>			
<b>SALARIES</b>			
1.00	Total salaries (see instructions)	29.40	1.00
2.00	Non-physician anesthetist Part A	0.00	2.00
3.00	Non-physician anesthetist Part B	0.00	3.00
4.00	Physician-Part A - Administrative	0.00	4.00
4.01	Physicians - Part A - Teaching	0.00	4.01
5.00	Physician-Part B	0.00	5.00
6.00	Non-physician-Part B	0.00	6.00
7.00	Interns & residents (in an approved program)	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)	0.00	7.01
8.00	Home office personnel	0.00	8.00
9.00	SNF	0.00	9.00
10.00	Excluded area salaries (see instructions)	23.54	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>			
11.00	Contract labor (see instructions)	78.94	11.00
12.00	Contract management and administrative services	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative	71.09	13.00
14.00	Home office salaries & wage-related costs	121.19	14.00
15.00	Home office: Physician Part A - Administrative	0.00	15.00
16.00	Home office and Contract Physicians Part A - Administrative	0.00	16.00
<b>AGE-RELATED COSTS</b>			
17.00	Wage-related costs (core) wkst S-3, Part IV line 24		17.00
18.00	Wage-related costs (other)wkst S-3, Part IV line 25		18.00
19.00	Excluded areas		19.00
20.00	Non-physician anesthetist Part A		20.00
21.00	Non-physician anesthetist Part B		21.00
22.00	Physician Part A - Administrative		22.00
22.01	Physician Part A - Teaching		22.01
23.00	Physician Part B		23.00
24.00	wage-related costs (RHC/FQHC)		24.00
25.00	Interns & residents (in an approved program)		25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>			
26.00	Employee Benefits	47.98	26.00
27.00	Administrative & General	32.05	27.00
28.00	Administrative & General under contract (see inst.)	335.45	28.00
29.00	Maintenance & Repairs	0.00	29.00
30.00	Operation of Plant	25.84	30.00
31.00	Laundry & Linen Service	0.00	31.00
32.00	Housekeeping	15.56	32.00
33.00	Housekeeping under contract (see instructions)	0.00	33.00
34.00	Dietary	15.83	34.00
35.00	Dietary under contract (see instructions)	0.00	35.00
36.00	Cafeteria	15.83	36.00
37.00	Maintenance of Personnel	0.00	37.00
38.00	Nursing Administration	40.43	38.00
39.00	Central Services and Supply	18.07	39.00
40.00	Pharmacy	34.66	40.00
41.00	Medical Records & Medical Records Library	23.86	41.00
42.00	Social Service	29.05	42.00
43.00	Other General Service	33.15	43.00

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet S-3  
Part III  
Date/Time Prepared:  
11/23/2012 3:41 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>						
1.00	Net salaries (see instructions)	63,717,708	0	63,717,708	2,153,103.53	1.00
2.00	Excluded area salaries (see instructions)	4,876,661	845,451	5,722,112	243,064.92	2.00
3.00	Subtotal salaries (line 1 minus line 2)	58,841,047	-845,451	57,995,596	1,910,038.61	3.00
4.00	Subtotal other wages & related costs (see inst.)	33,971,369	0	33,971,369	292,863.35	4.00
5.00	Subtotal wage-related costs (see inst.)	18,345,751	0	18,345,751	0.00	5.00
6.00	Total (sum of lines 3 thru 5)	111,158,167	-845,451	110,312,716	2,202,901.96	6.00
7.00	Total overhead cost (see instructions)	30,443,552	-4,514,050	25,929,502	914,704.88	7.00

		Average Hourly Wage (col. 4 ÷ col. 5)	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>			
1.00	Net salaries (see instructions)	29.59	1.00
2.00	Excluded area salaries (see instructions)	23.54	2.00
3.00	Subtotal salaries (line 1 minus line 2)	30.36	3.00
4.00	Subtotal other wages & related costs (see inst.)	116.00	4.00
5.00	Subtotal wage-related costs (see inst.)	31.63	5.00
6.00	Total (sum of lines 3 thru 5)	50.08	6.00
7.00	Total overhead cost (see instructions)	28.35	7.00

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet S-3  
Part IV  
Date/Time Prepared:  
11/23/2012 3:41 pm

		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	1,486,875	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	8,543,560	8.00
9.00	Prescription Drug Plan	2,086,317	9.00
10.00	Dental, Hearing and Vision Plan	633,558	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	75,965	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	459,512	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	673,838	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	6,808	14.00
15.00	'workers' Compensation Insurance	318,576	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	3,452,908	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	408,995	20.00
<b>OTHER</b>			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	198,840	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	18,345,752	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet S-3  
Part V  
Date/Time Prepared:  
11/23/2012 3:41 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	other	0	0	18.00



RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet A

Date/Time Prepared:  
11/23/2012 3:41 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 CAP REL COSTS-BLDG & FIXT		8,215,065	8,215,065	2,226,232	10,441,297	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		9,235,086	9,235,086	0	9,235,086	2.00
4.00	00400 EMPLOYEE BENEFITS	9,081,695	15,687,968	24,769,663	-7,182,940	17,586,723	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	5,226,959	330,436,614	335,663,573	-2,361,104	333,302,469	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700 OPERATION OF PLANT	1,484,647	4,418,581	5,903,228	191,798	6,095,026	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	152,804	152,804	0	152,804	8.00
9.00	00900 HOUSEKEEPING	1,179,798	786,568	1,966,366	152,415	2,118,781	9.00
10.00	01000 DIETARY	1,644,760	2,917,120	4,561,880	-3,950,898	610,982	10.00
11.00	01100 CAFETERIA	0	0	0	4,163,380	4,163,380	11.00
13.00	01300 NURSING ADMINISTRATION	1,122,068	671,930	1,793,998	144,957	1,938,955	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	301,910	316,753	618,663	39,003	657,666	14.00
15.00	01500 PHARMACY	2,042,548	955,619	2,998,167	263,872	3,262,039	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1,731,485	557,909	2,289,394	223,686	2,513,080	16.00
17.00	01700 SOCIAL SERVICE	1,071,648	2,177,642	3,249,290	292,527	3,541,817	17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	5,102,836	1,559,662	6,662,498	659,222	7,321,720	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	5,998,809	1,409,766	7,408,575	774,971	8,183,546	30.00
31.00	03100 INTENSIVE CARE UNIT	1,455,587	524,383	1,979,970	188,044	2,168,014	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	874,124	217,203	1,091,327	112,926	1,204,253	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	2,477,185	1,498,567	3,975,752	320,021	4,295,773	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,471,911	1,343,053	3,814,964	319,340	4,134,304	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	1,582,579	2,496,327	4,078,906	204,449	4,283,355	55.00
56.00	05600 RADIOISOTOPE	326,011	102,337	428,348	42,117	470,465	56.00
57.00	05700 CT SCAN	431,545	100,049	531,594	55,750	587,344	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	279,209	174,755	453,964	36,070	490,034	58.00
60.00	06000 LABORATORY	2,571,641	2,749,303	5,320,944	332,224	5,653,168	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	6,783	1,734,420	1,741,203	876	1,742,079	63.00
64.00	06400 INTRAVENOUS THERAPY	1,849,400	375,871	2,225,271	238,919	2,464,190	64.00
65.00	06500 RESPIRATORY THERAPY	666,437	164,117	830,554	86,095	916,649	65.00
66.00	06600 PHYSICAL THERAPY	686,244	259,598	945,842	88,654	1,034,496	66.00
69.00	06900 ELECTROCARDIOLOGY	310,656	107,963	418,619	40,133	458,752	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,271,355	12,271,355	0	12,271,355	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	76,430,568	76,430,568	0	76,430,568	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951 HOSPITAL NUTRITION	809,545	125,477	935,022	104,583	1,039,605	76.01
76.02	03952 PAIN MANAGEMENT	522,366	83,632	605,998	67,483	673,481	76.02
76.03	03954 INFUSION CENTER	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	3,900,212	882,405	4,782,617	503,858	5,286,475	90.00
91.00	09100 EMERGENCY	1,177,251	1,180,144	2,357,395	152,086	2,509,481	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE		4,149,716	4,149,716	-2,217,261	1,932,455	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	58,387,849	486,470,330	544,858,179	-3,686,512	541,171,667	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	22,221	115,096	137,317	2,871	140,188	190.00
191.00	19100 RESEARCH	287,662	50,787	338,449	37,162	375,611	191.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	4,566,778	15,297,309	19,864,087	3,646,479	23,510,566	194.00
200.00	TOTAL (SUM OF LINES 118-199)	63,264,510	501,933,522	565,198,032	0	565,198,032	200.00

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-2,342,216	8,099,081	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1,595,376	10,830,462	2.00
4.00	00400 EMPLOYEE BENEFITS	-472,972	17,113,751	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-275,080,741	58,221,728	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700 OPERATION OF PLANT	0	6,095,026	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	152,804	8.00
9.00	00900 HOUSEKEEPING	-17,459	2,101,322	9.00
10.00	01000 DIETARY	-1,371	609,611	10.00
11.00	01100 CAFETERIA	-3,353,831	809,549	11.00
13.00	01300 NURSING ADMINISTRATION	19,208	1,958,163	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	657,666	14.00
15.00	01500 PHARMACY	48	3,262,087	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-8,036	2,505,044	16.00
17.00	01700 SOCIAL SERVICE	-2,007,855	1,533,962	17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	-256,264	7,065,456	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS	-326	8,183,220	30.00
31.00	03100 INTENSIVE CARE UNIT	9	2,168,023	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	1,204,253	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	196	4,295,969	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	257	4,134,561	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	4,283,355	55.00
56.00	05600 RADIOISOTOPE	0	470,465	56.00
57.00	05700 CT SCAN	0	587,344	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	490,034	58.00
60.00	06000 LABORATORY	830	5,653,998	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	98	1,742,177	63.00
64.00	06400 INTRAVENOUS THERAPY	163	2,464,353	64.00
65.00	06500 RESPIRATORY THERAPY	-88	916,561	65.00
66.00	06600 PHYSICAL THERAPY	0	1,034,496	66.00
69.00	06900 ELECTROCARDIOLOGY	0	458,752	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES-CHARGED TO PATIENTS	0	12,271,355	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	76,430,568	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01	03951 HOSPITAL NUTRITION	25	1,039,630	76.01
76.02	03952 PAIN MANAGEMENT	0	673,481	76.02
76.03	03954 INFUSION CENTER	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	5,286,475	90.00
91.00	09100 EMERGENCY	-705,464	1,804,017	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE	-1,932,455	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-284,562,868	256,608,799	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	140,188	190.00
191.00	19100 RESEARCH	0	375,611	191.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	3	23,510,569	194.00
200.00	TOTAL (SUM OF LINES 118-199)	-284,562,865	280,635,167	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - RECLASS OF CAFETERIA EXPENSE</b>					
1.00	CAFETERIA	11.00	1,619,568	2,543,812	1.00
TOTALS			1,619,568	2,543,812	
<b>B - RECLASS OF EMPLOYEE BONUS</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	1,634,409	0	1.00
2.00	OPERATION OF PLANT	7.00	191,798	0	2.00
3.00	HOUSEKEEPING	9.00	152,415	0	3.00
4.00	DIETARY	10.00	212,482	0	4.00
5.00	NURSING ADMINISTRATION	13.00	144,957	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	39,003	0	6.00
7.00	PHARMACY	15.00	263,872	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	223,686	0	8.00
9.00	SOCIAL SERVICE	17.00	138,443	0	9.00
10.00	OTHER GENERAL SERVICE (SPECIFY)	18.00	659,222	0	10.00
11.00	ADULTS & PEDIATRICS	30.00	774,971	0	11.00
12.00	INTENSIVE CARE UNIT	31.00	188,044	0	12.00
13.00	SURGICAL INTENSIVE CARE UNIT	34.00	112,926	0	13.00
14.00	OPERATING ROOM	50.00	320,021	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	319,340	0	15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	204,449	0	16.00
17.00	RADIOISOTOPE	56.00	42,117	0	17.00
18.00	CT SCAN	57.00	55,750	0	18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	36,070	0	19.00
20.00	LABORATORY	60.00	332,224	0	20.00
21.00	BLOOD STORING, PROCESSING & TRANS.	63.00	876	0	21.00
22.00	INTRAVENOUS THERAPY	64.00	238,919	0	22.00
23.00	RESPIRATORY THERAPY	65.00	86,095	0	23.00
24.00	PHYSICAL THERAPY	66.00	88,654	0	24.00
25.00	ELECTROCARDIOLOGY	69.00	40,133	0	25.00
26.00	HOSPITAL NUTRITION	76.01	104,583	0	26.00
27.00	PAIN MANAGEMENT	76.02	67,483	0	27.00
28.00	CLINIC	90.00	503,858	0	28.00
29.00	EMERGENCY	91.00	152,086	0	29.00
30.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	2,871	0	30.00
31.00	RESEARCH	191.00	37,162	0	31.00
32.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	640,452	0	32.00
TOTALS			8,009,371	0	
<b>C - RECLASS OF PROP TAXES NOT REL TO PAT</b>					
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	482,223	1.00
TOTALS			0	482,223	
<b>D - CARE COORDINATION RECLASS</b>					
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	300,472	2,565,819	1.00
TOTALS			300,472	2,565,819	
<b>E - GUEST SERVICES RECLASS</b>					
1.00	SOCIAL SERVICE	17.00	36,377	117,707	1.00
TOTALS			36,377	117,707	
<b>F - RECLASS INTEREST EXPENSE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,217,261	1.00
TOTALS			0	2,217,261	
<b>G - INSURANCE PREMIUMS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	491,194	1.00
2.00	EMPLOYEE BENEFITS	4.00	0	826,431	2.00
TOTALS			0	1,317,625	
<b>H - TRANSPORTATION</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	99,129	89,274	1.00
TOTALS			99,129	89,274	
500.00	Grand Total: Increases		10,064,917	9,333,721	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - RECLASS OF CAFETERIA EXPENSE</b>							
1.00	DIETARY	10.00	1,619,568	2,543,812	0		1.00
	TOTALS		1,619,568	2,543,812			
<b>B - RECLASS OF EMPLOYEE BONUS</b>							
1.00	EMPLOYEE BENEFITS	4.00	8,009,371	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0		32.00
	TOTALS		8,009,371	0			
<b>C - RECLASS OF PROP TAXES NOT REL TO PAT</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	482,223	13		1.00
	TOTALS		0	482,223			
<b>D - CARE COORDINATION RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	300,472	2,565,819	0		1.00
	TOTALS		300,472	2,565,819			
<b>E - GUEST SERVICES RECLASS</b>							
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	36,377	117,707	0		1.00
	TOTALS		36,377	117,707			
<b>F - RECLASS INTEREST EXPENSE</b>							
1.00	INTEREST EXPENSE	113.00	0	2,217,261	11		1.00
	TOTALS		0	2,217,261			
<b>G - INSURANCE PREMIUMS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,317,625	12		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	1,317,625			
<b>H - TRANSPORTATION</b>							
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	99,129	89,274	0		1.00
	TOTALS		99,129	89,274			
500.00	Grand Total: Decreases		10,064,917	9,333,721			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
11/23/2012 3:41 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	1,081,457	0	0	0	1.00
2.00	Land Improvements	5,645,016	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	60,196,847	0	0	0	4.00
5.00	Fixed Equipment	3,811,381	0	0	0	5.00
6.00	Movable Equipment	5,428,047	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	76,162,748	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	76,162,748	0	0	0	10.00
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A COLUMN 2, LINES 1 and 2</b>						
1.00	CAP REL COSTS-BLDG & FIXT	3,058,354	2,499,494	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	791,656	2,402,060	0	0	2.00
3.00	Total (sum of lines 1-2)	3,850,010	4,901,554	0	0	3.00
<b>COMPUTATION OF RATIOS</b>						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT	66,923,320	0	66,923,320	0.878688	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,239,428	0	9,239,428	0.121312	2.00
3.00	Total (sum of lines 1-2)	76,162,748	0	76,162,748	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
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		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>								
1.00	Land	1,081,457	0					1.00
2.00	Land Improvements	5,645,016	0					2.00
3.00	Buildings and Fixtures	0	0					3.00
4.00	Building Improvements	60,196,847	0					4.00
5.00	Fixed Equipment	3,811,381	0					5.00
6.00	Movable Equipment	5,428,047	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	76,162,748	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	76,162,748	0					10.00
<b>SUMMARY OF CAPITAL</b>								
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)					
		14.00	15.00					
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>								
1.00	CAP REL COSTS-BLDG & FIXT	0	8,215,065					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,041,370	9,235,086					2.00
3.00	Total (sum of lines 1-2)	6,041,370	17,450,151					3.00
<b>ALLOCATION OF OTHER CAPITAL</b>								
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease		
		6.00	7.00	8.00	9.00	10.00		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>								
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,816,183	322,415	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,387,032	2,402,060	2.00	
3.00	Total (sum of lines 1-2)	0	0	0	6,203,215	2,724,475	3.00	



Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet A-8

Date/Time Prepared:  
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted			
			Cost Center		Line #	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-731,325	CAP REL COSTS-BLDG & FIXT		1.00	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP		2.00	2.00
3.00 Investment income - other (chapter 2)		0			0.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00	7.00
8.00 Television and radio service (chapter 21)		0			0.00	8.00
9.00 Parking lot (chapter 21)		0			0.00	9.00
10.00 Provider-based physician adjustment	A-8-2	-705,464				10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-263,605,483				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Cafeteria-employees and guests	B	-1,103,201	CAFETERIA		11.00	14.00
15.00 Rental of quarters to employee and others		0			0.00	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	16.00
17.00 Sale of drugs to other than patients		0			0.00	17.00
18.00 Sale of medical records and abstracts		0			0.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	19.00
20.00 Vending machines	B	-1,184	CAFETERIA		11.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***		114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	-10,053	CAP REL COSTS-BLDG & FIXT		1.00	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-701,073	CAP REL COSTS-MVBLE EQUIP		2.00	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00	28.00
29.00 Physicians' assistant		0			0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	32.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	33.00
33.01 OTHER REVENUE	B	-20	EMPLOYEE BENEFITS		4.00	33.01
33.02 OTHER REVENUE	B	-2,300,818	ADMINISTRATIVE & GENERAL		5.00	33.02
33.03 OTHER REVENUE	B	-126,967	SOCIAL SERVICE		17.00	33.03
33.04 OTHER REVENUE	B	-8,200	MEDICAL RECORDS & LIBRARY		16.00	33.04
33.05 NON-ALLOWABLE EXPENSE	A	-1,880,888	SOCIAL SERVICE		17.00	33.05
33.06 NON-ALLOWABLE EXPENSE		0			0.00	33.06
33.07 NON-ALLOWABLE EXPENSE	A	-418	ADULTS & PEDIATRICS		30.00	33.07
33.08 NON-ALLOWABLE EXPENSE	A	-13	OPERATING ROOM		50.00	33.08
33.09 NON-ALLOWABLE EXPENSE	A	-83	LABORATORY		60.00	33.09
33.10 NON-ALLOWABLE EXPENSE	A	-16	RADIOLOGY-DIAGNOSTIC		54.00	33.10
33.11 NON-ALLOWABLE EXPENSE		0			0.00	33.11
33.12 NON-ALLOWABLE EXPENSE	A	-27	MEDICAL RECORDS & LIBRARY		16.00	33.12
33.13 NON-ALLOWABLE EXPENSE	A	-261,592	OTHER GENERAL SERVICE (SPECIFY)		18.00	33.13
33.14 NON-ALLOWABLE EXPENSE	A	-1,371	DIETARY		10.00	33.14
33.15 NON-ALLOWABLE EXPENSE		0			0.00	33.15
33.16 NON-ALLOWABLE EXPENSE	A	-10,886,547	ADMINISTRATIVE & GENERAL		5.00	33.16
33.17 NON-ALLOWABLE EXPENSE	A	-5,667	EMPLOYEE BENEFITS		4.00	33.17
33.18 CAFETERIA	A	-2,249,446	CAFETERIA		11.00	33.18
33.19 NON-ALLOWABLE EXPENSE		0			0.00	33.19
33.20 EMR AMORTIZATION	A	92	ADULTS & PEDIATRICS		30.00	33.20

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet A-8

Date/Time Prepared:  
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted		Line #	
			Cost Center			
			1.00	2.00		
33.21 EMR AMORTIZATION	A		9	INTENSIVE CARE UNIT	31.00	33.21
33.22 EMR AMORTIZATION	A		209	OPERATING ROOM	50.00	33.22
33.23 EMR AMORTIZATION	A		163	INTRAVENOUS THERAPY	64.00	33.23
33.24 EMR AMORTIZATION	A		913	LABORATORY	60.00	33.24
33.25 EMR AMORTIZATION	A		98	BLOOD STORING, PROCESSING & TRANS.	63.00	33.25
33.26 EMR AMORTIZATION	A		55	RESPIRATORY THERAPY	65.00	33.26
33.27 EMR AMORTIZATION	A		273	RADIOLOGY-DIAGNOSTIC	54.00	33.27
33.28 EMR AMORTIZATION	A		48	PHARMACY	15.00	33.28
33.29 EMR AMORTIZATION	A		25	HOSPITAL NUTRITION	76.01	33.29
33.30 EMR AMORTIZATION	A		3	OTHER NONREIMBURSABLE COST CENTERS	194.00	33.30
33.31 EMR AMORTIZATION	A	5,328		OTHER GENERAL SERVICE (SPECIFY)	18.00	33.31
33.32 EMR AMORTIZATION	A	7,978		ADMINISTRATIVE & GENERAL	5.00	33.32
33.33 EMR AMORTIZATION	A	191		MEDICAL RECORDS & LIBRARY	16.00	33.33
33.34 EMR AMORTIZATION	A	19,300		NURSING ADMINISTRATION	13.00	33.34
33.35 NON-ALLOWABLE EXPENSE	A	-143		RESPIRATORY THERAPY	65.00	33.35
33.36		0			0.00	33.36
33.37		0			0.00	33.37
33.38 NON-ALLOWABLE EXPENSE	A	-92		NURSING ADMINISTRATION	13.00	33.38
33.39 NON-ALLOWABLE EXPENSE	A	-17,459		HOUSEKEEPING	9.00	33.39
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-284,562,865				50.00

Cost Center Description		kst. A-7 Ref.	
		5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	9	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)	0	33.00
33.01	OTHER REVENUE	0	33.01
33.02	OTHER REVENUE	0	33.02
33.03	OTHER REVENUE	0	33.03
33.04	OTHER REVENUE	0	33.04
33.05	NON-ALLOWABLE EXPENSE	0	33.05
33.06	NON-ALLOWABLE EXPENSE	0	33.06
33.07	NON-ALLOWABLE EXPENSE	0	33.07
33.08	NON-ALLOWABLE EXPENSE	0	33.08
33.09	NON-ALLOWABLE EXPENSE	0	33.09
33.10	NON-ALLOWABLE EXPENSE	0	33.10
33.11	NON-ALLOWABLE EXPENSE	0	33.11
33.12	NON-ALLOWABLE EXPENSE	0	33.12
33.13	NON-ALLOWABLE EXPENSE	0	33.13
33.14	NON-ALLOWABLE EXPENSE	0	33.14
33.15	NON-ALLOWABLE EXPENSE	0	33.15
33.16	NON-ALLOWABLE EXPENSE	0	33.16
33.17	NON-ALLOWABLE EXPENSE	0	33.17
33.18	CAFETERIA	0	33.18
33.19		0	33.19
33.20	EMR AMORTIZATION	0	33.20
33.21	EMR AMORTIZATION	0	33.21
33.22	EMR AMORTIZATION	0	33.22
33.23	EMR AMORTIZATION	0	33.23
33.24	EMR AMORTIZATION	0	33.24
33.25	EMR AMORTIZATION	0	33.25
33.26	EMR AMORTIZATION	0	33.26
33.27	EMR AMORTIZATION	0	33.27

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
33.28	EMR AMORTIZATION	0	33.28
33.29	EMR AMORTIZATION	0	33.29
33.30	EMR AMORTIZATION	0	33.30
33.31	EMR AMORTIZATION	0	33.31
33.32	EMR AMORTIZATION	0	33.32
33.33	EMR AMORTIZATION	0	33.33
33.34	EMR AMORTIZATION	0	33.34
33.35	NON-ALLOWABLE EXPENSE	0	33.35
33.36		0	33.36
33.37		0	33.37
33.38	NON-ALLOWABLE EXPENSE	0	33.38
33.39	NON-ALLOWABLE EXPENSE	0	33.39
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 140100

Period: From 07/01/2011 To 06/30/2012

Worksheet A-8-1

Date/Time Prepared: 11/23/2012 3:41 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	RISING TIDE IP REIMBURSEMENT	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	TRAVEL - AIR CHARTER	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	GUARANTEE FEES	4.00
4.01	113.00	INTEREST EXPENSE	INTEREST EXPENSE - OTHER	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	AMORT EXP - GCF CAP LEASES	4.02
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	AMORT EXP - GCF CAP LEASES - R	4.03
4.04	113.00	INTEREST EXPENSE	INTEREST EXPENSE - GCF	4.04
4.05	113.00	INTEREST EXPENSE	INTEREST EXPENSE - CAPITAL LEA	4.05
4.06	1.00	CAP REL COSTS-BLDG & FIXT	RENTAL - BLDG	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICES	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	CORPORATE ALLOCATION	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	INSURANCE - COMMERCIAL	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	INSURANCE - STELLAR	4.10
4.11	1.00	CAP REL COSTS-BLDG & FIXT	INSURANCE - STELLAR	4.11
4.12	4.00	EMPLOYEE BENEFITS	INSURANCE - STELLAR	4.12
4.13	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	4.13
4.14	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	4.15
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.			5.00

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

	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	

**B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND OR HOME OFFICE:**

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

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

6.00	A	MIDWESTERN REG	100.00	6.00
7.00	A	MIDWESTERN REG	100.00	7.00
8.00	A	MIDWESTERN REG	100.00	8.00
9.00	A	MIDWESTERN REG	100.00	9.00
10.00	A	MIDWESTERN REG	100.00	10.00
10.01	A	MIDWESTERN REG	100.00	10.01
10.02	A	MIDWESTERN REG	100.00	10.02
10.03	A	MIDWESTERN REG	100.00	10.03
10.04	A	MIDWESTERN REG	100.00	10.04
10.05	A	MIDWESTERN REG	100.00	10.05
10.06	A	MIDWESTERN REG	100.00	10.06
10.07			0.00	10.07
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: 140100

Period: From 07/01/2011 To 06/30/2012

Worksheet A-8-1

Date/Time Prepared: 11/23/2012 3:41 pm

	Amount of Allowable Cost 4.00	Amount Included in ks. A, column 5 5.00	Net Adjustments (col. 4 minus col. 5)* 6.00	Wkst. A-7 Ref. 7.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	0	82,826,551	-82,826,551	0	1.00
2.00	0	-160,661	160,661	0	2.00
3.00	168,865	2,640,000	-2,471,135	0	3.00
4.00	0	78,867	-78,867	0	4.00
4.01	0	95,625	-95,625	0	4.01
4.02	2,279,656	2,279,656	0	9	4.02
4.03	0	1,117,095	-1,117,095	9	4.03
4.04	0	477,174	-477,174	0	4.04
4.05	2,217,261	3,576,917	-1,359,656	0	4.05
4.06	322,415	2,499,494	-2,177,079	10	4.06
4.07	0	57,950,644	-57,950,644	0	4.07
4.08	0	162,337,585	-162,337,585	0	4.08
4.09	391,691	464,574	-72,883	0	4.09
4.10	311,456	4,530,822	-4,219,366	0	4.10
4.11	299,553	491,194	-191,641	11	4.11
4.12	359,146	826,431	-467,285	0	4.12
4.13	767,882	0	767,882	9	4.13
4.14	3,413,544	0	3,413,544	9	4.14
4.15	47,895,016	0	47,895,016	0	4.15
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	58,426,485	322,031,968	-263,605,483	5.00

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

Related Organization(s) and/or Home Office			
Name	Percentage of Ownership	Type of Business	
4-00	5.00	6.00	

**B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:**

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	NIMP	100.00	PROPERTY	6.00
7.00	CTCA	100.00	MANAGEMENT	7.00
8.00	ICIC	100.00	CONSULTING	8.00
9.00	INTERNATIONAL A	100.00	CORPORATE JET	9.00
10.00	SCL	100.00	SECURITIES FINA	10.00
10.01	EXPEDITION PROP	100.00	RENTS BLDG SHAR	10.01
10.02	BUCKLEY RD PR	100.00	PROPERTY COMP	10.02
10.03	LAND TRUST	100.00	PROPERTY COMP	10.03
10.04	GCF	100.00	FINANCIAL	10.04
10.05	STELLAR INS	100.00	INSURANCE	10.05
10.06	ICMC	100.00	CAPITAL MANAGEM	10.06
10.07		0.00		10.07
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.

	kst. A Line #		Cost Center/Physician Identifier	Total	Professional	
	1.00	2.00		Remuneration	Component	
	91.00	EMERGENCY	1,036,728	705,464	1.00	
1.00	0.00		0	0	2.00	
2.00	0.00		0	0	3.00	
3.00	0.00		0	0	4.00	
4.00	0.00		0	0	5.00	
5.00	0.00		0	0	6.00	
6.00	0.00		0	0	7.00	
7.00	0.00		0	0	8.00	
8.00	0.00		0	0	9.00	
9.00	0.00		0	0	10.00	
10.00	0.00		0	0	200.00	
200.00			1,036,728	705,464		

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	331,264	177,220	4,660	397,041	19,852	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	331,264		4,660	397,041	19,852	200.00

Provider CCN: 140100

Period:  
 From 07/01/2011  
 To 06/30/2012

Worksheet A-8-2

Date/Time Prepared:  
 11/23/2012 3:41 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	397,041	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	397,041	200.00

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	705,464	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	705,464	200.00

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS-BLDG & FIXT	8,099,081	8,099,081				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	10,830,462		10,830,462			2.00
4.00 00400 EMPLOYEE BENEFITS	17,113,751	261,720	4,245	17,379,716		4.00
5.00 00500 ADMINISTRATIVE & GENERAL	58,221,728	303,597	4,844,509	1,861,157	65,230,991	5.00
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700 OPERATION OF PLANT	6,095,026	2,037,673	932,362	468,486	9,533,547	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	152,804	0	0	0	152,804	8.00
9.00 00900 HOUSEKEEPING	2,101,322	130,956	2,673	372,290	2,607,241	9.00
10.00 01000 DIETARY	609,611	50,766	56,894	66,418	783,689	10.00
11.00 01100 CAFETERIA	809,549	346,010	0	452,592	1,608,151	11.00
13.00 01300 NURSING ADMINISTRATION	1,958,163	273,636	6,747	354,073	2,592,619	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	657,666	76,895	7,357	95,269	837,187	14.00
15.00 01500 PHARMACY	3,262,087	134,711	99,878	644,534	4,141,210	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	2,505,044	150,228	10,519	546,376	3,212,167	16.00
17.00 01700 SOCIAL SERVICE	1,533,962	39,961	9,941	345,792	1,929,656	17.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	7,065,456	105,209	10,376	1,610,219	8,791,260	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	8,183,220	947,266	26,123	1,892,929	11,049,538	30.00
31.00 03100 INTENSIVE CARE UNIT	2,168,023	131,301	97,454	459,316	2,856,094	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	1,204,253	0	0	275,833	1,480,086	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	4,295,969	512,598	377,824	781,685	5,968,076	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	4,134,561	235,399	395,842	780,021	5,545,823	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	4,283,355	503,441	2,316,821	499,389	7,603,006	55.00
56.00 05600 RADIOISOTOPE	470,465	11,916	0	102,874	585,255	56.00
57.00 05700 CT SCAN	587,344	25,364	210,879	136,176	959,763	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	490,034	29,348	232,523	88,105	840,010	58.00
60.00 06000 LABORATORY	5,653,998	277,697	197,839	811,491	6,941,025	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	1,742,177	11,188	15,590	2,140	1,771,095	63.00
64.00 06400 INTRAVENOUS THERAPY	2,464,353	242,066	0	583,585	3,290,004	64.00
65.00 06500 RESPIRATORY THERAPY	916,561	39,118	20,664	210,297	1,186,640	65.00
66.00 06600 PHYSICAL THERAPY	1,034,496	55,900	5,811	216,547	1,312,754	66.00
69.00 06900 ELECTROCARDIOLOGY	458,752	9,808	75,718	98,029	642,307	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12,271,355	22,107	0	0	12,293,462	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	76,430,568	0	0	0	76,430,568	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01 03951 HOSPITAL NUTRITION	1,039,630	26,168	0	255,455	1,321,253	76.01
76.02 03952 PAIN MANAGEMENT	673,481	8,965	0	164,834	847,280	76.02
76.03 03954 INFUSION CENTER	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	5,286,475	831,942	438,216	1,230,726	7,787,359	90.00
91.00 09100 EMERGENCY	1,804,017	127,891	22,826	371,486	2,326,220	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	256,608,799	7,960,845	10,419,631	15,778,124	254,458,140	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	140,188	16,130	0	7,012	163,330	190.00
191.00 19100 RESEARCH	375,611	26,590	341	90,773	493,315	191.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	23,510,569	95,516	410,490	1,503,807	25,520,382	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	280,635,167	8,099,081	10,830,462	17,379,716	280,635,167	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet B  
Part I  
Date/Time Prepared:  
11/23/2012 3:41 pm

Cost Center Description		ADMINISTRATIVE & GENERAL 5.00	MAINTENANCE & REPAIRS 6.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	65,230,991					5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700 OPERATION OF PLANT	2,887,054		12,420,601			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	46,274		0	199,078		8.00
9.00	00900 HOUSEKEEPING	789,553		295,947	0	3,692,741	9.00
10.00	01000 DIETARY	237,325		114,725	0	34,941	10.00
11.00	01100 CAFETERIA	486,998		781,948	0	238,154	11.00
13.00	01300 NURSING ADMINISTRATION	785,125		618,389	0	188,339	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	253,526		173,776	0	52,926	14.00
15.00	01500 PHARMACY	1,254,087		304,432	0	92,719	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	972,744		339,499	0	103,399	16.00
17.00	01700 SOCIAL SERVICE	584,360		90,308	686	27,505	17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	2,662,266		237,762	0	72,414	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	3,346,143	0	2,140,728	68,097	651,991	30.00
31.00	03100 INTENSIVE CARE UNIT	864,914	0	296,726	9,743	90,372	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	448,216	0	0	0	0	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,807,318	0	1,158,419	23,914	352,814	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,679,447	0	531,978	34,766	162,022	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	2,302,426	0	1,137,725	12,695	346,511	55.00
56.00	05600 RADIOISOTOPE	177,233	0	26,928	0	8,201	56.00
57.00	05700 CT SCAN	290,646	0	57,319	0	17,457	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	254,381	0	66,324	0	20,200	58.00
60.00	06000 LABORATORY	2,101,958	0	627,567	0	191,135	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	536,342	0	25,283	0	7,700	63.00
64.00	06400 INTRAVENOUS THERAPY	996,315	0	547,043	23,370	166,610	64.00
65.00	06500 RESPIRATORY THERAPY	359,351	0	88,403	0	26,924	65.00
66.00	06600 PHYSICAL THERAPY	397,543	0	126,327	5,767	38,475	66.00
69.00	06900 ELECTROCARDIOLOGY	194,510	0	22,166	588	6,751	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,722,841	0	49,959	0	15,216	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	23,145,475	0	0	0	0	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951 HOSPITAL NUTRITION	400,116	0	59,137	0	18,011	76.01
76.02	03952 PAIN MANAGEMENT	256,583	0	20,261	836	6,171	76.02
76.03	03954 INFUSION CENTER	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	2,358,254	0	1,880,104	6,959	572,613	90.00
91.00	09100 EMERGENCY	704,452	0	289,020	11,657	88,025	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	57,303,776	0	12,108,203	199,078	3,597,596	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	49,461	0	36,452	0	11,102	190.00
191.00	19100 RESEARCH	149,391	0	60,090	0	18,301	191.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	7,728,363	0	215,856	0	65,742	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)	65,230,991	0	12,420,601	199,078	3,692,741	202.00

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	1,170,680					10.00
11.00	01100	0	3,115,251				11.00
13.00	01300	0	59,038	4,243,510			13.00
14.00	01400	0	35,547	0	1,352,962		14.00
15.00	01500	0	125,339	0	0	5,917,787	15.00
16.00	01600	0	154,327	0	0	0	16.00
17.00	01700	0	80,838	0	0	0	17.00
18.00	01850	0	327,425	0	0	0	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	841,376	393,350	1,777,560	0	0	30.00
31.00	03100	58,047	80,917	380,926	0	0	31.00
34.00	03400	0	61,709	290,503	0	0	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	172,554	812,318	0	0	50.00
54.00	05400	0	122,177	0	0	0	54.00
55.00	05500	0	140,205	0	0	0	55.00
56.00	05600	0	17,211	0	0	0	56.00
57.00	05700	0	25,445	0	0	0	57.00
58.00	05800	0	14,276	0	0	0	58.00
60.00	06000	0	193,950	0	0	0	60.00
63.00	06300	0	537	0	0	0	63.00
64.00	06400	260,134	98,320	462,854	0	0	64.00
65.00	06500	0	39,742	0	0	0	65.00
66.00	06600	0	44,890	0	0	0	66.00
69.00	06900	0	16,134	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	1,352,962	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	5,917,787	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	0	66,192	0	0	0	76.01
76.02	03952	0	25,554	0	0	0	76.02
76.03	03954	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	284,189	147,202	0	0	90.00
91.00	09100	11,123	79,052	372,147	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		1,170,680	2,658,918	4,243,510	1,352,962	5,917,787	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	3,394	0	0	0	190.00
191.00	19100	0	20,538	0	0	0	191.00
194.00	07950	0	432,401	0	0	0	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,170,680	3,115,251	4,243,510	1,352,962	5,917,787	202.00

Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	16.00	17.00	18.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
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	4,782,136					16.00
17.00 01700 SOCIAL SERVICE	0	2,713,353				17.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	12,091,127			18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	93,091	52,820	235,354	20,650,048	0	30.00
31.00 03100 INTENSIVE CARE UNIT	16,312	9,255	41,240	4,704,546	0	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	11,950	6,781	30,213	2,329,458	0	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	210,653	119,524	532,577	11,158,167	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	215,321	122,173	544,380	8,958,087	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	261,357	148,293	660,767	12,612,985	0	55.00
56.00 05600 RADIOISOTOPE	23,629	13,407	59,738	911,602	0	56.00
57.00 05700 CT SCAN	356,120	202,062	900,349	2,809,161	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	60,815	34,506	153,754	1,444,266	0	58.00
60.00 06000 LABORATORY	296,857	168,436	750,520	11,271,448	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	34,060	19,326	86,112	2,480,455	0	63.00
64.00 06400 INTRAVENOUS THERAPY	123,518	70,084	312,281	6,350,533	0	64.00
65.00 06500 RESPIRATORY THERAPY	10,443	5,925	26,402	1,743,830	0	65.00
66.00 06600 PHYSICAL THERAPY	9,842	5,584	24,883	1,966,065	0	66.00
69.00 06900 ELECTROCARDIOLOGY	23,619	13,401	59,714	979,190	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	139,647	79,235	353,058	18,006,380	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	2,858,900	1,622,113	7,228,763	117,203,606	0	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01 03951 HOSPITAL NUTRITION	3,075	1,745	7,775	1,877,304	0	76.01
76.02 03952 PAIN MANAGEMENT	3,601	2,043	9,105	1,171,434	0	76.02
76.03 03954 INFUSION CENTER	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	22,344	12,678	56,490	13,128,192	0	90.00
91.00 09100 EMERGENCY	6,982	3,962	17,652	3,910,292	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	4,782,136	2,713,353	12,091,127	245,667,049	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	263,739	0	190.00
191.00 19100 RESEARCH	0	0	0	741,635	0	191.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	33,962,744	0	194.00
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	4,782,136	2,713,353	12,091,127	280,635,167	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet B  
Part I  
Date/Time Prepared:  
11/23/2012 3:41 pm

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
6.00	00600 MAINTENANCE & REPAIRS		6.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)		18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS	20,650,048	30.00
31.00	03100 INTENSIVE CARE UNIT	4,704,546	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	2,329,458	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	11,158,167	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,958,087	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	12,612,985	55.00
56.00	05600 RADIOISOTOPE	911,602	56.00
57.00	05700 CT SCAN	2,809,161	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,444,266	58.00
60.00	06000 LABORATORY	11,271,448	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,480,455	63.00
64.00	06400 INTRAVENOUS THERAPY	6,350,533	64.00
65.00	06500 RESPIRATORY THERAPY	1,743,830	65.00
66.00	06600 PHYSICAL THERAPY	1,966,065	66.00
69.00	06900 ELECTROCARDIOLOGY	979,190	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18,006,380	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	117,203,606	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	76.00
76.01	03951 HOSPITAL NUTRITION	1,877,304	76.01
76.02	03952 PAIN MANAGEMENT	1,171,434	76.02
76.03	03954 INFUSION CENTER	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000 CLINIC	13,128,192	90.00
91.00	09100 EMERGENCY	3,910,292	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	245,667,049	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	263,739	190.00
191.00	19100 RESEARCH	741,635	191.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	33,962,744	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	280,635,167	202.00

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS	0	261,720	4,245	265,965	265,965	4.00
5.00 00500 ADMINISTRATIVE & GENERAL	0	303,597	4,844,509	5,148,106	28,485	5.00
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700 OPERATION OF PLANT	0	2,037,673	932,362	2,970,035	7,170	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00 00900 HOUSEKEEPING	0	130,956	2,673	133,629	5,698	9.00
10.00 01000 DIETARY	0	50,766	56,894	107,660	1,017	10.00
11.00 01100 CAFETERIA	0	346,010	0	346,010	6,927	11.00
13.00 01300 NURSING ADMINISTRATION	0	273,636	6,747	280,383	5,419	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	76,895	7,357	84,252	1,458	14.00
15.00 01500 PHARMACY	0	134,711	99,878	234,589	9,865	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	150,228	10,519	160,747	8,362	16.00
17.00 01700 SOCIAL SERVICE	0	39,961	9,941	49,902	5,292	17.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	105,209	10,376	115,585	24,644	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	0	947,266	26,123	973,389	28,940	30.00
31.00 03100 INTENSIVE CARE UNIT	0	131,301	97,454	228,755	7,030	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	4,222	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	512,598	377,824	890,422	11,964	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	235,399	395,842	631,241	11,938	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	503,441	2,316,821	2,820,262	7,643	55.00
56.00 05600 RADIOISOTOPE	0	11,916	0	11,916	1,574	56.00
57.00 05700 CT SCAN	0	25,364	210,879	236,243	2,084	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	29,348	232,523	261,871	1,348	58.00
60.00 06000 LABORATORY	0	277,697	197,839	475,536	12,420	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	11,188	15,590	26,778	33	63.00
64.00 06400 INTRAVENOUS THERAPY	0	242,066	0	242,066	8,932	64.00
65.00 06500 RESPIRATORY THERAPY	0	39,118	20,664	59,782	3,219	65.00
66.00 06600 PHYSICAL THERAPY	0	55,900	5,811	61,711	3,314	66.00
69.00 06900 ELECTROCARDIOLOGY	0	9,808	75,718	85,526	1,500	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,107	0	22,107	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01 03951 HOSPITAL NUTRITION	0	26,168	0	26,168	3,910	76.01
76.02 03952 PAIN MANAGEMENT	0	8,965	0	8,965	2,523	76.02
76.03 03954 INFUSION CENTER	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	831,942	438,216	1,270,158	18,836	90.00
91.00 09100 EMERGENCY	0	127,891	22,826	150,717	5,686	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE	0	7,960,845	10,419,631	18,380,476	241,453	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)				118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,130	0	16,130	107	190.00
191.00 19100 RESEARCH	0	26,590	341	26,931	1,389	191.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	95,516	410,490	506,006	23,016	194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		TOTAL (sum lines 118-201)				202.00

Cost Center Description		ADMINISTRATIVE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPING	
		& GENERAL	REPAIRS	PLANT	LINEN SERVICE		
		5.00	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	5,176,591					5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700 OPERATION OF PLANT	229,110		3,206,315			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	3,672		0	3,672		8.00
9.00	00900 HOUSEKEEPING	62,657		76,397	0	278,381	9.00
10.00	01000 DIETARY	18,834		29,616	0	2,634	10.00
11.00	01100 CAFETERIA	38,647		201,856	0	17,953	11.00
13.00	01300 NURSING ADMINISTRATION	62,306		159,634	0	14,198	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	20,119		44,859	0	3,990	14.00
15.00	01500 PHARMACY	99,522		78,588	0	6,990	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	77,195		87,640	0	7,795	16.00
17.00	01700 SOCIAL SERVICE	46,373		23,313	13	2,073	17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	211,272		61,377	0	5,459	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	265,542	0	552,618	1,257	49,152	30.00
31.00	03100 INTENSIVE CARE UNIT	68,638	0	76,598	180	6,813	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	35,569	0	0	0	0	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	143,425	0	299,040	441	26,597	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	133,277	0	137,327	641	12,214	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	182,715	0	293,698	234	26,122	55.00
56.00	05600 RADIOISOTOPE	14,065	0	6,951	0	618	56.00
57.00	05700 CT SCAN	23,065	0	14,797	0	1,316	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	20,187	0	17,121	0	1,523	58.00
60.00	06000 LABORATORY	166,807	0	162,003	0	14,409	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	42,563	0	6,527	0	580	63.00
64.00	06400 INTRAVENOUS THERAPY	79,065	0	141,216	431	12,560	64.00
65.00	06500 RESPIRATORY THERAPY	28,517	0	22,821	0	2,030	65.00
66.00	06600 PHYSICAL THERAPY	31,548	0	32,611	106	2,900	66.00
69.00	06900 ELECTROCARDIOLOGY	15,436	0	5,722	11	509	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	295,436	0	12,897	0	1,147	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,836,779	0	0	0	0	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951 HOSPITAL NUTRITION	31,752	0	15,266	0	1,358	76.01
76.02	03952 PAIN MANAGEMENT	20,362	0	5,230	15	465	76.02
76.03	03954 INFUSION CENTER	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	187,146	0	485,339	128	43,167	90.00
91.00	09100 EMERGENCY	55,904	0	74,609	215	6,636	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	4,547,505	0	3,125,671	3,672	271,208	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,925	0	9,410	0	837	190.00
191.00	19100 RESEARCH	11,855	0	15,512	0	1,380	191.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	613,306	0	55,722	0	4,956	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)	5,176,591	0	3,206,315	3,672	278,381	202.00

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	159,761					10.00
11.00	01100	0	611,393				11.00
13.00	01300	0	11,587	533,527			13.00
14.00	01400	0	6,976	0	161,654		14.00
15.00	01500	0	24,599	0	0	454,153	15.00
16.00	01600	0	30,288	0	0	0	16.00
17.00	01700	0	15,865	0	0	0	17.00
18.00	01850	0	64,260	0	0	0	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	114,821	77,198	223,489	0	0	30.00
31.00	03100	7,922	15,881	47,893	0	0	31.00
34.00	03400	0	12,111	36,524	0	0	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	33,865	102,131	0	0	50.00
54.00	05400	0	23,978	0	0	0	54.00
55.00	05500	0	27,516	0	0	0	55.00
56.00	05600	0	3,378	0	0	0	56.00
57.00	05700	0	4,994	0	0	0	57.00
58.00	05800	0	2,802	0	0	0	58.00
60.00	06000	0	38,064	0	0	0	60.00
63.00	06300	0	105	0	0	0	63.00
64.00	06400	35,500	19,296	58,194	0	0	64.00
65.00	06500	0	7,800	0	0	0	65.00
66.00	06600	0	8,810	0	0	0	66.00
69.00	06900	0	3,166	0	0	0	69.00
70.00	07000	0	0	0	161,654	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	454,153	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	0	12,991	0	0	0	76.01
76.02	03952	0	5,015	0	0	0	76.02
76.03	03954	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	55,775	18,507	0	0	90.00
91.00	09100	1,518	15,515	46,789	0	0	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		159,761	521,835	533,527	161,654	454,153	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	666	0	0	0	190.00
191.00	19100	0	4,031	0	0	0	191.00
194.00	07950	0	84,861	0	0	0	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		159,761	611,393	533,527	161,654	454,153	202.00

Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	16.00	17.00	18.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
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	372,027					16.00
17.00 01700 SOCIAL SERVICE	0	142,831				17.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	482,597			18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	7,238	2,778	9,392	2,305,814	0	30.00
31.00 03100 INTENSIVE CARE UNIT	1,268	487	1,646	463,111	0	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	929	357	1,206	90,918	0	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	16,378	6,286	21,253	1,551,802	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	16,741	6,426	21,724	995,507	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	20,321	7,799	26,369	3,412,679	0	55.00
56.00 05600 RADIOISOTOPE	1,837	705	2,384	43,428	0	56.00
57.00 05700 CT SCAN	27,689	10,627	35,930	356,745	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	4,728	1,815	6,136	317,531	0	58.00
60.00 06000 LABORATORY	23,081	8,859	29,951	931,130	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	2,648	1,016	3,436	83,686	0	63.00
64.00 06400 INTRAVENOUS THERAPY	9,604	3,686	12,462	623,012	0	64.00
65.00 06500 RESPIRATORY THERAPY	812	312	1,054	126,347	0	65.00
66.00 06600 PHYSICAL THERAPY	765	294	993	143,052	0	66.00
69.00 06900 ELECTROCARDIOLOGY	1,836	705	2,383	116,794	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10,858	4,167	14,089	522,355	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	222,495	85,438	288,558	2,887,423	0	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01 03951 HOSPITAL NUTRITION	239	92	310	92,086	0	76.01
76.02 03952 PAIN MANAGEMENT	280	107	363	43,325	0	76.02
76.03 03954 INFUSION CENTER	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	1,737	667	2,254	2,083,714	0	90.00
91.00 09100 EMERGENCY	543	208	704	359,044	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	372,027	142,831	482,597	17,549,503	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	31,075	0	190.00
191.00 19100 RESEARCH	0	0	0	61,098	0	191.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	1,287,867	0	194.00
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	372,027	142,831	482,597	18,929,543	0	202.00

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
6.00	00600 MAINTENANCE & REPAIRS		6.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)		18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS	2,305,814	30.00
31.00	03100 INTENSIVE CARE UNIT	463,111	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	90,918	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	1,551,802	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	995,507	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	3,412,679	55.00
56.00	05600 RADIOISOTOPE	43,428	56.00
57.00	05700 CT SCAN	356,745	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	317,531	58.00
60.00	06000 LABORATORY	931,130	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	83,686	63.00
64.00	06400 INTRAVENOUS THERAPY	623,012	64.00
65.00	06500 RESPIRATORY THERAPY	126,347	65.00
66.00	06600 PHYSICAL THERAPY	143,052	66.00
69.00	06900 ELECTROCARDIOLOGY	116,794	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	522,355	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,887,423	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	76.00
76.01	03951 HOSPITAL NUTRITION	92,086	76.01
76.02	03952 PAIN MANAGEMENT	43,325	76.02
76.03	03954 INFUSION CENTER	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000 CLINIC	2,083,714	90.00
91.00	09100 EMERGENCY	359,044	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	17,549,503	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,075	190.00
191.00	19100 RESEARCH	61,098	191.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	1,287,867	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	18,929,543	202.00

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 CAP REL COSTS-BLDG & FIXT	211,389						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		10,093,554					2.00
4.00 00400 EMPLOYEE BENEFITS	6,831	3,956	62,192,187				4.00
5.00 00500 ADMINISTRATIVE & GENERAL	7,924	4,514,887	6,660,025	-65,230,991	215,404,176		5.00
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0		6.00
7.00 00700 OPERATION OF PLANT	53,184	868,924	1,676,445	0	9,533,547		7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	0	0	152,804		8.00
9.00 00900 HOUSEKEEPING	3,418	2,491	1,332,213	0	2,607,241		9.00
10.00 01000 DIETARY	1,325	53,023	237,674	0	783,689		10.00
11.00 01100 CAFETERIA	9,031	0	1,619,568	0	1,608,151		11.00
13.00 01300 NURSING ADMINISTRATION	7,142	6,288	1,267,025	0	2,592,619		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	2,007	6,856	340,913	0	837,187		14.00
15.00 01500 PHARMACY	3,516	93,082	2,306,420	0	4,141,210		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	3,921	9,803	1,955,171	0	3,212,167		16.00
17.00 01700 SOCIAL SERVICE	1,043	9,265	1,237,394	0	1,929,656		17.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	2,746	9,670	5,762,058	0	8,791,260		18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	24,724	24,346	6,773,780	0	11,049,538		30.00
31.00 03100 INTENSIVE CARE UNIT	3,427	90,823	1,643,631	0	2,856,094		31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	987,050	0	1,480,086		34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	13,379	352,117	2,797,206	0	5,968,076		50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	6,144	368,909	2,791,251	0	5,545,823		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	13,140	2,159,183	1,787,028	0	7,603,006		55.00
56.00 05600 RADIOISOTOPE	311	0	368,128	0	585,255		56.00
57.00 05700 CT SCAN	662	196,531	487,295	0	959,763		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	766	216,702	315,279	0	840,010		58.00
60.00 06000 LABORATORY	7,248	184,378	2,903,865	0	6,941,025		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	292	14,529	7,659	0	1,771,095		63.00
64.00 06400 INTRAVENOUS THERAPY	6,318	0	2,088,319	0	3,290,004		64.00
65.00 06500 RESPIRATORY THERAPY	1,021	19,258	752,532	0	1,186,640		65.00
66.00 06600 PHYSICAL THERAPY	1,459	5,416	774,898	0	1,312,754		66.00
69.00 06900 ELECTROCARDIOLOGY	256	70,566	350,789	0	642,307		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	577	0	0	0	12,293,462		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	76,430,568		73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0		76.00
76.01 03951 HOSPITAL NUTRITION	683	0	914,128	0	1,321,253		76.01
76.02 03952 PAIN MANAGEMENT	234	0	589,849	0	847,280		76.02
76.03 03954 INFUSION CENTER	0	0	0	0	0		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	21,714	408,400	4,404,070	0	7,787,359		90.00
91.00 09100 EMERGENCY	3,338	21,273	1,329,337	0	2,326,220		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)							92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300 INTEREST EXPENSE							113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	207,781	9,710,676	56,461,000	-65,230,991	189,227,149		118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	421	0	25,092	0	163,330		190.00
191.00 19100 RESEARCH	694	318	324,824	0	493,315		191.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	2,493	382,560	5,381,271	0	25,520,382		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)	8,099,081	10,830,462	17,379,716		65,230,991		202.00
203.00 Unit cost multiplier (wkst. B, Part I)	38.313635	1.073008	0.279452		0.302831		203.00
204.00 Cost to be allocated (per wkst. B, Part II)			265,965		5,176,591		204.00
205.00 Unit cost multiplier (wkst. B, Part II)			0.004277		0.024032		205.00

Cost Center Description		MAINTENANCE & REPAIRS (SQ. FEET)	OPERATION OF PLANT (SQ. FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQ. FEET)	DIETARY (TIME SPENT)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS	196,634					6.00
7.00	00700 OPERATION OF PLANT	53,184	143,450				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	498,986			8.00
9.00	00900 HOUSEKEEPING	3,418	3,418	0	140,032		9.00
10.00	01000 DIETARY	1,325	1,325	0	1,325	37,996	10.00
11.00	01100 CAFETERIA	9,031	9,031	0	9,031	0	11.00
13.00	01300 NURSING ADMINISTRATION	7,142	7,142	0	7,142	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	2,007	2,007	0	2,007	0	14.00
15.00	01500 PHARMACY	3,516	3,516	0	3,516	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	3,921	3,921	0	3,921	0	16.00
17.00	01700 SOCIAL SERVICE	1,043	1,043	1,719	1,043	0	17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	2,746	2,746	0	2,746	0	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	24,724	24,724	170,684	24,724	27,308	30.00
31.00	03100 INTENSIVE CARE UNIT	3,427	3,427	24,420	3,427	1,884	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	13,379	13,379	59,939	13,379	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,144	6,144	87,141	6,144	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	13,140	13,140	31,820	13,140	0	55.00
56.00	05600 RADIOISOTOPE	311	311	0	311	0	56.00
57.00	05700 CT SCAN	662	662	0	662	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	766	766	0	766	0	58.00
60.00	06000 LABORATORY	7,248	7,248	0	7,248	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	292	292	0	292	0	63.00
64.00	06400 INTRAVENOUS THERAPY	6,318	6,318	58,577	6,318	8,443	64.00
65.00	06500 RESPIRATORY THERAPY	1,021	1,021	0	1,021	0	65.00
66.00	06600 PHYSICAL THERAPY	1,459	1,459	14,455	1,459	0	66.00
69.00	06900 ELECTROCARDIOLOGY	256	256	1,475	256	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	577	577	0	577	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951 HOSPITAL NUTRITION	683	683	0	683	0	76.01
76.02	03952 PAIN MANAGEMENT	234	234	2,095	234	0	76.02
76.03	03954 INFUSION CENTER	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	21,714	21,714	17,443	21,714	0	90.00
91.00	09100 EMERGENCY	3,338	3,338	29,218	3,338	361	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	193,026	139,842	498,986	136,424	37,996	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	421	421	0	421	0	190.00
191.00	19100 RESEARCH	694	694	0	694	0	191.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	2,493	2,493	0	2,493	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)	0	12,420,601	199,078	3,692,741	1,170,680	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	0.000000	86.584880	0.398965	26.370694	30.810612	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	0	3,206,315	3,672	278,381	159,761	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.000000	22.351446	0.007359	1.987981	4.204679	205.00

Cost Center Description		CAFETERIA (ASSIGNED TIME)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA	1,653,819					11.00
13.00	01300 NURSING ADMINISTRATION	31,342	478,540				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	18,871	0	100			14.00
15.00	01500 PHARMACY	66,540	0	0	100		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	81,929	0	0	0	970,877,635	16.00
17.00	01700 SOCIAL SERVICE	42,915	0	0	0	0	17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	173,823	0	0	0	0	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	208,821	200,455	0	0	18,897,859	30.00
31.00	03100 INTENSIVE CARE UNIT	42,957	42,957	0	0	3,311,367	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	32,760	32,760	0	0	2,425,971	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	91,605	91,605	0	0	42,763,497	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	64,861	0	0	0	43,711,222	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	74,432	0	0	0	53,056,589	55.00
56.00	05600 RADIOISOTOPE	9,137	0	0	0	4,796,693	56.00
57.00	05700 CT SCAN	13,508	0	0	0	72,293,932	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	7,579	0	0	0	12,345,730	58.00
60.00	06000 LABORATORY	102,964	0	0	0	60,263,380	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	285	0	0	0	6,914,391	63.00
64.00	06400 INTRAVENOUS THERAPY	52,196	52,196	0	0	25,074,759	64.00
65.00	06500 RESPIRATORY THERAPY	21,098	0	0	0	2,119,949	65.00
66.00	06600 PHYSICAL THERAPY	23,831	0	0	0	1,998,003	66.00
69.00	06900 ELECTROCARDIOLOGY	8,565	0	0	0	4,794,789	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	100	0	28,348,975	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	100	580,451,939	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	624,281	76.00
76.01	03951 HOSPITAL NUTRITION	35,140	0	0	0	731,060	76.01
76.02	03952 PAIN MANAGEMENT	13,566	0	0	0	0	76.02
76.03	03954 INFUSION CENTER	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	150,870	16,600	0	0	4,535,860	90.00
91.00	09100 EMERGENCY	41,967	41,967	0	0	1,417,389	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE			100	100	970,877,635	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,411,562	478,540	100	100	970,877,635	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,802	0	0	0	0	190.00
191.00	19100 RESEARCH	10,903	0	0	0	0	191.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	229,552	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)	3,115,251	4,243,510	1,352,962	5,917,787	4,782,136	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	1.883671	8.867618	13,529.620000	59,177.870000	0.004926	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	611,393	533,527	161,654	454,153	372,027	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.369686	1.114906	1,616.540000	4,541.530000	0.000383	205.00

Cost Center Description	SOCIAL SERVICE (GROSS CHARGES)	OTHER GENERAL SERVICE (SPECIFY) (GROSS CHARGES)		
			18.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100 CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS			4.00
5.00	00500 ADMINISTRATIVE & GENERAL			5.00
6.00	00600 MAINTENANCE & REPAIRS			6.00
7.00	00700 OPERATION OF PLANT			7.00
8.00	00800 LAUNDRY & LINEN SERVICE			8.00
9.00	00900 HOUSEKEEPING			9.00
10.00	01000 DIETARY			10.00
11.00	01100 CAFETERIA			11.00
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	970,877,635		17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	970,877,635	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS	18,897,859	18,897,859	30.00
31.00	03100 INTENSIVE CARE UNIT	3,311,367	3,311,367	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	2,425,971	2,425,971	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	42,763,497	42,763,497	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	43,711,222	43,711,222	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	53,056,589	53,056,589	55.00
56.00	05600 RADIOISOTOPE	4,796,693	4,796,693	56.00
57.00	05700 CT SCAN	72,293,932	72,293,932	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	12,345,730	12,345,730	58.00
60.00	06000 LABORATORY	60,263,380	60,263,380	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	6,914,391	6,914,391	63.00
64.00	06400 INTRAVENOUS THERAPY	25,074,759	25,074,759	64.00
65.00	06500 RESPIRATORY THERAPY	2,119,949	2,119,949	65.00
66.00	06600 PHYSICAL THERAPY	1,998,003	1,998,003	66.00
69.00	06900 ELECTROCARDIOLOGY	4,794,789	4,794,789	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	28,348,975	28,348,975	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	580,451,939	580,451,939	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01	03951 HOSPITAL NUTRITION	624,281	624,281	76.01
76.02	03952 PAIN MANAGEMENT	731,060	731,060	76.02
76.03	03954 INFUSION CENTER	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	4,535,860	4,535,860	90.00
91.00	09100 EMERGENCY	1,417,389	1,417,389	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	970,877,635	970,877,635	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100 RESEARCH	0	0	191.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	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)	2,713,353	12,091,127	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	0.002795	0.012454	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	142,831	482,597	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.000147	0.000497	205.00

Provider CCN: 140100	Period: From 07/01/2011 To 06/30/2012	Worksheet C Part I Date/Time Prepared: 11/23/2012 3:41 pm
Title XVIII		Hospital
		PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
			Total Costs	RCE Disallowance		
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		20,650,048	0	20,650,048	30.00
31.00	03100 INTENSIVE CARE UNIT		4,704,546	0	4,704,546	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		2,329,458	0	2,329,458	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		11,158,167	0	11,158,167	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		8,958,087	0	8,958,087	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		12,612,985	0	12,612,985	55.00
56.00	05600 RADIOISOTOPE		911,602	0	911,602	56.00
57.00	05700 CT SCAN		2,809,161	0	2,809,161	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1,444,266	0	1,444,266	58.00
60.00	06000 LABORATORY		11,271,448	0	11,271,448	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		2,480,455	0	2,480,455	63.00
64.00	06400 INTRAVENOUS THERAPY		6,350,533	0	6,350,533	64.00
65.00	06500 RESPIRATORY THERAPY	0	1,743,830	0	1,743,830	65.00
66.00	06600 PHYSICAL THERAPY	0	1,966,065	0	1,966,065	66.00
69.00	06900 ELECTROCARDIOLOGY		979,190	0	979,190	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		18,006,380	0	18,006,380	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		117,203,606	0	117,203,606	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	76.00
76.01	03951 HOSPITAL NUTRITION		1,877,304	0	1,877,304	76.01
76.02	03952 PAIN MANAGEMENT		1,171,434	0	1,171,434	76.02
76.03	03954 INFUSION CENTER		0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC		13,128,192	0	13,128,192	90.00
91.00	09100 EMERGENCY		3,910,292	0	3,910,292	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,141,191	0	1,141,191	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		246,808,240	0	246,808,240	200.00
201.00	Less Observation Beds		1,141,191		1,141,191	201.00
202.00	Total (see instructions)		245,667,049	0	245,667,049	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
11/23/2012 3:41 pm

Cost Center Description		Charges			Hospital	PPS		
		Inpatient	Outpatient	Total (col. 6 + col. 7)			Cost or Other Ratio	TEFRA Inpatient Ratio
		6.00	7.00	8.00				
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000 ADULTS & PEDIATRICS	18,069,574		18,069,574		30.00		
31.00	03100 INTENSIVE CARE UNIT	3,311,367		3,311,367		31.00		
34.00	03400 SURGICAL INTENSIVE CARE UNIT	2,425,971		2,425,971		34.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000 OPERATING ROOM	21,002,463	21,761,034	42,763,497	0.260927	50.00		
54.00	05400 RADIOLOGY-DIAGNOSTIC	7,468,692	36,242,530	43,711,222	0.204938	54.00		
55.00	05500 RADIOLOGY-THERAPEUTIC	1,883,966	51,172,623	53,056,589	0.237727	55.00		
56.00	05600 RADIOISOTOPE	341,463	4,455,230	4,796,693	0.190048	56.00		
57.00	05700 CT SCAN	5,043,889	67,250,043	72,293,932	0.038857	57.00		
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,226,742	11,118,988	12,345,730	0.116985	58.00		
60.00	06000 LABORATORY	13,248,975	47,014,405	60,263,380	0.187036	60.00		
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	4,648,503	2,265,888	6,914,391	0.358738	63.00		
64.00	06400 INTRAVENOUS THERAPY	77,870	24,996,889	25,074,759	0.253264	64.00		
65.00	06500 RESPIRATORY THERAPY	1,711,468	408,481	2,119,949	0.822581	65.00		
66.00	06600 PHYSICAL THERAPY	1,286,523	711,480	1,998,003	0.984015	66.00		
69.00	06900 ELECTROCARDIOLOGY	1,261,022	3,533,767	4,794,789	0.204220	69.00		
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15,848,416	12,500,559	28,348,975	0.635169	71.00		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00		
73.00	07300 DRUGS CHARGED TO PATIENTS	75,028,104	505,423,835	580,451,939	0.201918	73.00		
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.00		
76.01	03951 HOSPITAL NUTRITION	20,722	603,559	624,281	3.007146	76.01		
76.02	03952 PAIN MANAGEMENT	107,154	623,906	731,060	1.602377	76.02		
76.03	03954 INFUSION CENTER	0	0	0	0.000000	76.03		
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000 CLINIC	562,150	3,973,710	4,535,860	2.894312	90.00		
91.00	09100 EMERGENCY	158,657	1,258,732	1,417,389	2.758799	91.00		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	247,786	580,499	828,285	1.377776	92.00		
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300 INTEREST EXPENSE					113.00		
200.00	Subtotal (see instructions)	174,981,477	795,896,158	970,877,635		200.00		
201.00	Less observation Beds					201.00		
202.00	Total (see instructions)	174,981,477	795,896,158	970,877,635		202.00		



Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Cost
			Total Costs	RCE	Disallowance	Total Costs	
							3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	20,650,048		20,650,048		0	30.00
31.00	03100 INTENSIVE CARE UNIT	4,704,546		4,704,546		0	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	2,329,458		2,329,458		0	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	11,158,167		11,158,167		0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,958,087		8,958,087		0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	12,612,985		12,612,985		0	55.00
56.00	05600 RADIOISOTOPE	911,602		911,602		0	56.00
57.00	05700 CT SCAN	2,809,161		2,809,161		0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,444,266		1,444,266		0	58.00
60.00	06000 LABORATORY	11,271,448		11,271,448		0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,480,455		2,480,455		0	63.00
64.00	06400 INTRAVENOUS THERAPY	6,350,533		6,350,533		0	64.00
65.00	06500 RESPIRATORY THERAPY	1,743,830	0	1,743,830		0	65.00
66.00	06600 PHYSICAL THERAPY	1,966,065	0	1,966,065		0	66.00
69.00	06900 ELECTROCARDIOLOGY	979,190		979,190		0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0		0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18,006,380		18,006,380		0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	117,203,606		117,203,606		0	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0		0		0	76.00
76.01	03951 HOSPITAL NUTRITION	1,877,304		1,877,304		0	76.01
76.02	03952 PAIN MANAGEMENT	1,171,434		1,171,434		0	76.02
76.03	03954 INFUSION CENTER	0		0		0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	13,128,192		13,128,192		0	90.00
91.00	09100 EMERGENCY	3,910,292		3,910,292		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,141,191		1,141,191		0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	246,808,240	0	246,808,240		0	200.00
201.00	Less observation Beds	1,141,191		1,141,191		0	201.00
202.00	Total (see instructions)	245,667,049	0	245,667,049		0	202.00

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	18,069,574		18,069,574			30.00
31.00 03100 INTENSIVE CARE UNIT	3,311,367		3,311,367			31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	2,425,971		2,425,971			34.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	21,002,463	21,761,034	42,763,497	0.260927	0.000000	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	7,468,692	36,242,530	43,711,222	0.204938	0.000000	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	1,883,966	51,172,623	53,056,589	0.237727	0.000000	55.00
56.00 05600 RADIOISOTOPE	341,463	4,455,230	4,796,693	0.190048	0.000000	56.00
57.00 05700 CT SCAN	5,043,889	67,250,043	72,293,932	0.038857	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1,226,742	11,118,988	12,345,730	0.116985	0.000000	58.00
60.00 06000 LABORATORY	13,248,975	47,014,405	60,263,380	0.187036	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	4,648,503	2,265,888	6,914,391	0.358738	0.000000	63.00
64.00 06400 INTRAVENOUS THERAPY	77,870	24,996,889	25,074,759	0.253264	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	1,711,468	408,481	2,119,949	0.822581	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	1,286,523	711,480	1,998,003	0.984015	0.000000	66.00
69.00 06900 ELECTROCARDIOLOGY	1,261,022	3,533,767	4,794,789	0.204220	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15,848,416	12,500,559	28,348,975	0.635169	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	75,028,104	505,423,835	580,451,939	0.201918	0.000000	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.01 03951 HOSPITAL NUTRITION	20,722	603,559	624,281	3.007146	0.000000	76.01
76.02 03952 PAIN MANAGEMENT	107,154	623,906	731,060	1.602377	0.000000	76.02
76.03 03954 INFUSION CENTER	0	0	0	0.000000	0.000000	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	562,150	3,973,710	4,535,860	2.894312	0.000000	90.00
91.00 09100 EMERGENCY	158,657	1,258,732	1,417,389	2.758799	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	247,786	580,499	828,285	1.377776	0.000000	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	174,981,477	795,896,158	970,877,635			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	174,981,477	795,896,158	970,877,635			202.00

Provider CCN: 140100

Period:  
 From 07/01/2011  
 To 06/30/2012

Worksheet C  
 Part I  
 Date/Time Prepared:  
 11/23/2012 3:41 pm

Title XIX

Hospital

Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			34.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.01	03951 HOSPITAL NUTRITION	0.000000		76.01
76.02	03952 PAIN MANAGEMENT	0.000000		76.02
76.03	03954 INFUSION CENTER	0.000000		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140100

Period: From 07/01/2011 To 06/30/2012

Worksheet C Part II Date/Time Prepared: 11/23/2012 3:41 pm

Cost Center Description	Title XIX			Hospital	Cost	
	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	11,158,167	1,551,802	9,606,365	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	8,958,087	995,507	7,962,580	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	12,612,985	3,412,679	9,200,306	0	0	55.00
56.00 05600 RADIOISOTOPE	911,602	43,428	868,174	0	0	56.00
57.00 05700 CT SCAN	2,809,161	356,745	2,452,416	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1,444,266	317,531	1,126,735	0	0	58.00
60.00 06000 LABORATORY	11,271,448	931,130	10,340,318	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	2,480,455	83,686	2,396,769	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	6,350,533	623,012	5,727,521	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	1,743,830	126,347	1,617,483	0	0	65.00
66.00 06600 PHYSICAL THERAPY	1,966,065	143,052	1,823,013	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	979,190	116,794	862,396	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18,006,380	522,355	17,484,025	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	117,203,606	2,887,423	114,316,183	0	0	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01 03951 HOSPITAL NUTRITION	1,877,304	92,086	1,785,218	0	0	76.01
76.02 03952 PAIN MANAGEMENT	1,171,434	43,325	1,128,109	0	0	76.02
76.03 03954 INFUSION CENTER	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	13,128,192	2,083,714	11,044,478	0	0	90.00
91.00 09100 EMERGENCY	3,910,292	359,044	3,551,248	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,141,191	127,427	1,013,764	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE						113.00
200.00	Subtotal (sum of lines 50 thru 199)	219,124,188	14,817,087	204,307,101	0	200.00
201.00	Less Observation Beds	1,141,191	127,427	1,013,764	0	201.00
202.00	Total (line 200 minus line 201)	217,982,997	14,689,660	203,293,337	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140100

Period: From 07/01/2011 To 06/30/2012

Worksheet C Part II Date/Time Prepared: 11/23/2012 3:41 pm

Cost Center Description		Title XIX			Hospital	Cost
		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
		6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	11,158,167	42,763,497	0.260927		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,958,087	43,711,222	0.204938		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	12,612,985	53,056,589	0.237727		55.00
56.00	05600 RADIOISOTOPE	911,602	4,796,693	0.190048		56.00
57.00	05700 CT SCAN	2,809,161	72,293,932	0.038857		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,444,266	12,345,730	0.116985		58.00
60.00	06000 LABORATORY	11,271,448	60,263,380	0.187036		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,480,455	6,914,391	0.358738		63.00
64.00	06400 INTRAVENOUS THERAPY	6,350,533	25,074,759	0.253264		64.00
65.00	06500 RESPIRATORY THERAPY	1,743,830	2,119,949	0.822581		65.00
66.00	06600 PHYSICAL THERAPY	1,966,065	1,998,003	0.984015		66.00
69.00	06900 ELECTROCARDIOLOGY	979,190	4,794,789	0.204220		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18,006,380	28,348,975	0.635169		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	117,203,606	580,451,939	0.201918		73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000		76.00
76.01	03951 HOSPITAL NUTRITION	1,877,304	624,281	3.007146		76.01
76.02	03952 PAIN MANAGEMENT	1,171,434	731,060	1.602377		76.02
76.03	03954 INFUSION CENTER	0	0	0.000000		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	13,128,192	4,535,860	2.894312		90.00
91.00	09100 EMERGENCY	3,910,292	1,417,389	2.758799		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,141,191	828,285	1.377776		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (sum of lines 50 thru 199)	219,124,188	947,070,723			200.00
201.00	Less Observation Beds	1,141,191	0			201.00
202.00	Total (line 200 minus line 201)	217,982,997	947,070,723			202.00



APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

worksheet D  
Part I  
Date/Time Prepared:  
11/23/2012 3:41 pm

Title XVIII

Hospital

PPS

Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS	1,550	280,550	30.00
31.00	03100 INTENSIVE CARE UNIT	135	97,840	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	82	16,243	34.00
200.00	Total (lines 30-199)	1,767	394,633	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet D  
Part II  
Date/Time Prepared:  
11/23/2012 3:41 pm

Cost Center Description	Title XVIII			Hospital	PPS	
	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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	1,551,802	42,763,497	0.036288	1,804,606	65,486 50.00
		995,507	43,711,222	0.022775	350,922	7,992 54.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,412,679	53,056,589	0.064321	938,145	60,342 55.00
55.00	05500 RADIOLOGY-THERAPEUTIC	43,428	4,796,693	0.009054	97,787	885 56.00
56.00	05600 RADIOISOTOPE	356,745	72,293,932	0.004935	726,935	3,587 57.00
57.00	05700 CT SCAN	317,531	12,345,730	0.025720	221,045	5,685 58.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	931,130	60,263,380	0.015451	1,925,260	29,747 60.00
60.00	06000 LABORATORY	83,686	6,914,391	0.012103	954,758	11,555 63.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	623,012	25,074,759	0.024846	69,473	1,726 64.00
64.00	06400 INTRAVENOUS THERAPY	126,347	2,119,949	0.059599	363,088	21,640 65.00
65.00	06500 RESPIRATORY THERAPY	143,052	1,998,003	0.071597	199,498	14,283 66.00
66.00	06600 PHYSICAL THERAPY	116,794	4,794,789	0.024359	265,517	6,468 69.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0 70.00
70.00	07000 ELECTROENCEPHALOGRAPHY	522,355	28,348,975	0.018426	1,830,285	33,725 71.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0 72.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	10,072,833	50,102 73.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,887,423	580,451,939	0.004974	0	0 76.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0 76.01
76.01	03951 HOSPITAL NUTRITION	92,086	624,281	0.147507	2,786	411 76.02
76.02	03952 PAIN MANAGEMENT	43,325	731,060	0.059263	9,239	548 76.03
76.03	03954 INFUSION CENTER	0	0	0.000000	0	0 90.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	2,083,714	4,535,860	0.459387	120,641	55,421 91.00
91.00	09100 EMERGENCY	359,044	1,417,389	0.253314	27,799	7,042 92.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	127,427	828,285	0.153844	0	0 200.00
200.00	Total (lines 50-199)	14,817,087	947,070,723		19,980,617	376,645

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet D  
Part III  
Date/Time Prepared:  
11/23/2012 3:41 pm

Cost Center Description	Title XVIII				Hospital	PPS
	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	0	0	0	0	0 30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0 31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0 34.00
200.00	Total (lines 30-199)	0	0	0	0	0 200.00

Cost Center Description	Title XVIII			Hospital		PSA Adj. Nursing School	PPS
	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)			
	6.00	7.00	8.00	9.00		11.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	12,739	0.00	1,550	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	639	0.00	135	0	0	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	459	0.00	82	0	0	34.00
200.00	Total (lines 30-199)	13,837		1,767	0	0	200.00

Cost Center Description	Title XVIII		Hospital	PPS
	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
	12.00	13.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				30.00
30.00 03000 ADULTS & PEDIATRICS	0	0		31.00
31.00 03100 INTENSIVE CARE UNIT	0	0		34.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0		200.00
200.00 Total (lines 30-199)	0	0		

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet D  
Part IV  
Date/Time Prepared:  
11/23/2012 3:41 pm

Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4) 5.00	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All other Medical Education Cost				
	1.00	2.00	3.00	4.00				
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	0	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140100

Period: From 07/01/2011 To 06/30/2012

Worksheet D Part IV Date/Time Prepared: 11/23/2012 3:41 pm

Cost Center Description		Title XVIII			Hospital		
		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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	42,763,497	0.000000	0.000000	1,804,606	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	43,711,222	0.000000	0.000000	350,922	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	53,056,589	0.000000	0.000000	938,145	55.00
56.00	05600 RADIOISOTOPE	0	4,796,693	0.000000	0.000000	97,787	56.00
57.00	05700 CT SCAN	0	72,293,932	0.000000	0.000000	726,935	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	12,345,730	0.000000	0.000000	221,045	58.00
60.00	06000 LABORATORY	0	60,263,380	0.000000	0.000000	1,925,260	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	6,914,391	0.000000	0.000000	954,758	63.00
64.00	06400 INTRAVENOUS THERAPY	0	25,074,759	0.000000	0.000000	69,473	64.00
65.00	06500 RESPIRATORY THERAPY	0	2,119,949	0.000000	0.000000	363,088	65.00
66.00	06600 PHYSICAL THERAPY	0	1,998,003	0.000000	0.000000	199,498	66.00
69.00	06900 ELECTROCARDIOLOGY	0	4,794,789	0.000000	0.000000	265,517	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	28,348,975	0.000000	0.000000	1,830,285	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	580,451,939	0.000000	0.000000	10,072,833	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.01	03951 HOSPITAL NUTRITION	0	624,281	0.000000	0.000000	2,786	76.01
76.02	03952 PAIN MANAGEMENT	0	731,060	0.000000	0.000000	9,239	76.02
76.03	03954 INFUSION CENTER	0	0	0.000000	0.000000	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	4,535,860	0.000000	0.000000	120,641	90.00
91.00	09100 EMERGENCY	0	1,417,389	0.000000	0.000000	27,799	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	828,285	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	947,070,723			19,980,617	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet D  
Part IV  
Date/Time Prepared:  
11/23/2012 3:41 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School		
		11.00	12.00	13.00	21.00	22.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000 OPERATING ROOM	0	2,427,724	0	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	2,465,049	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	6,466,449	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	534,270	0	0	0	0	56.00
57.00	05700 CT SCAN	0	8,515,102	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,112,568	0	0	0	0	58.00
60.00	06000 LABORATORY	0	1,128,661	0	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	209,417	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	2,374,284	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	60,606	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	372,394	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	918,392	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	47,248,375	0	0	0	0	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	76.00
76.01	03951 HOSPITAL NUTRITION	0	0	0	0	0	0	76.01
76.02	03952 PAIN MANAGEMENT	0	11,393	0	0	0	0	76.02
76.03	03954 INFUSION CENTER	0	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000 CLINIC	0	448,037	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	100,504	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	74,393,225	0	0	0	0	200.00

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Hospital	PPS
		23.00	24.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					50.00
50.00	05000 OPERATING ROOM	0	0		54.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0		55.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0		56.00
56.00	05600 RADIOISOTOPE	0	0		57.00
57.00	05700 CT SCAN	0	0		58.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		60.00
60.00	06000 LABORATORY	0	0		63.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		64.00
64.00	06400 INTRAVENOUS THERAPY	0	0		65.00
65.00	06500 RESPIRATORY THERAPY	0	0		66.00
66.00	06600 PHYSICAL THERAPY	0	0		69.00
69.00	06900 ELECTROCARDIOLOGY	0	0		70.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		71.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		72.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		73.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		76.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.01
76.01	03951 HOSPITAL NUTRITION	0	0		76.02
76.02	03952 PAIN MANAGEMENT	0	0		76.03
76.03	03954 INFUSION CENTER	0	0		
<b>OUTPATIENT SERVICE COST CENTERS</b>					90.00
90.00	09000 CLINIC	0	0		91.00
91.00	09100 EMERGENCY	0	0		92.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		200.00
200.00	Total (lines 50-199)	0	0		

Title XVIII

Hospital

PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges			
			Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.260927	2,427,724	0	0		50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.204938	2,465,049	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.237727	6,466,449	0	0		55.00
56.00 05600 RADIOISOTOPE	0.190048	534,270	0	0		56.00
57.00 05700 CT SCAN	0.038857	8,515,102	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.116985	1,112,568	0	0		58.00
60.00 06000 LABORATORY	0.187036	1,128,661	0	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.358738	209,417	0	0		63.00
64.00 06400 INTRAVENOUS THERAPY	0.253264	2,374,284	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0.822581	60,606	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0.984015	0	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0.204220	372,394	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.635169	918,392	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	34,636		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.201918	47,248,375	0	0		73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0		76.00
76.01 03951 HOSPITAL NUTRITION	3.007146	0	0	0		76.01
76.02 03952 PAIN MANAGEMENT	1.602377	11,393	0	0		76.02
76.03 03954 INFUSION CENTER	0.000000	0	0	0		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	2.894312	448,037	0	0		90.00
91.00 09100 EMERGENCY	2.758799	100,504	612	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.377776	0	0	0		92.00
200.00 Subtotal (see instructions)		74,393,225	612	34,636		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 +/- line 201)		74,393,225	612	34,636		202.00

Title XVIII

Hospital

PPS

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	633,459	0	0		50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	505,182	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	1,537,250	0	0		55.00
56.00 05600 RADIOISOTOPE	101,537	0	0		56.00
57.00 05700 CT SCAN	330,871	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	130,154	0	0		58.00
60.00 06000 LABORATORY	211,100	0	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	75,126	0	0		63.00
64.00 06400 INTRAVENOUS THERAPY	601,321	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	49,853	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	76,050	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	583,334	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	9,540,297	0	6,994		73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
76.01 03951 HOSPITAL NUTRITION	0	0	0		76.01
76.02 03952 PAIN MANAGEMENT	18,256	0	0		76.02
76.03 03954 INFUSION CENTER	0	0	0		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	1,296,759	0	0		90.00
91.00 09100 EMERGENCY	277,270	1,688	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00 Subtotal (see instructions)	15,967,819	1,688	6,994		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0	0		201.00
202.00 Net Charges (line 200 +/- line 201)	15,967,819	1,688	6,994		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet D  
Part I  
Date/Time Prepared:  
11/23/2012 3:41 pm

Cost Center Description	Title XIX			Hospital	Cost	
	Capital Related Cost (from wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	2,305,814	0	2,305,814	12,739	181.00	30.00
31.00 03100 INTENSIVE CARE UNIT	463,111		463,111	639	724.74	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	90,918		90,918	459	198.08	34.00
200.00 Total (lines 30-199)	2,859,843		2,859,843	13,837		200.00

Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS	19	3,439	30.00
31.00	03100 INTENSIVE CARE UNIT	5	3,624	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	34.00
200.00	Total (lines 30-199)	24	7,063	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet D  
Part II  
Date/Time Prepared:  
11/23/2012 3:41 pm

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)	Hospital		Capital Costs (column 3 x column 4)
				Inpatient Program Charges	Cost	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	1,551,802	42,763,497	0.036288	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	995,507	43,711,222	0.022775	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	3,412,679	53,056,589	0.064321	0	0	55.00
56.00 05600 RADIOISOTOPE	43,428	4,796,693	0.009054	0	0	56.00
57.00 05700 CT SCAN	356,745	72,293,932	0.004935	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	317,531	12,345,730	0.025720	0	0	58.00
60.00 06000 LABORATORY	931,130	60,263,380	0.015451	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	83,686	6,914,391	0.012103	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	623,012	25,074,759	0.024846	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	126,347	2,119,949	0.059599	0	0	65.00
66.00 06600 PHYSICAL THERAPY	143,052	1,998,003	0.071597	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	116,794	4,794,789	0.024359	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	522,355	28,348,975	0.018426	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2,887,423	580,451,939	0.004974	0	0	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.01 03951 HOSPITAL NUTRITION	92,086	624,281	0.147507	0	0	76.01
76.02 03952 PAIN MANAGEMENT	43,325	731,060	0.059263	0	0	76.02
76.03 03954 INFUSION CENTER	0	0	0.000000	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	2,083,714	4,535,860	0.459387	0	0	90.00
91.00 09100 EMERGENCY	359,044	1,417,389	0.253314	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	828,285	0.000000	0	0	92.00
200.00 Total (lines 50-199)	14,689,660	947,070,723		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet D  
Part III  
Date/Time Prepared:  
11/23/2012 3:41 pm

Cost Center Description	Title XIX				Hospital	Total Costs (sum of cols. 1 through 3, minus col. 4)		
	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Cost			
	1.00	2.00	3.00	4.00	5.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet D  
Part III  
Date/Time Prepared:  
11/23/2012 3:41 pm

Cost Center Description	Title XIX			Hospital		PSA Adj. Nursing School	Cost
	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)			
	6.00	7.00	8.00	9.00	11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	12,739	0.00	19	0	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	639	0.00	5	0	0	0	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	459	0.00	0	0	0	0	34.00
200.00 Total (lines 30-199)	13,837		24	0	0	0	200.00

Cost Center Description	Title XIX		Hospital	Cost
	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
	12.00	13.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 03000 ADULTS & PEDIATRICS	0	0		30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0		34.00
200.00 Total (lines 30-199)	0	0		200.00

Cost Center Description	Title XIX			Hospital	Cost
	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
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0	0	0	0	0 50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0 56.00
57.00 05700 CT SCAN	0	0	0	0	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
60.00 06000 LABORATORY	0	0	0	0	0 60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0 66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.00
76.01 03951 HOSPITAL NUTRITION	0	0	0	0	0 76.01
76.02 03952 PAIN MANAGEMENT	0	0	0	0	0 76.02
76.03 03954 INFUSION CENTER	0	0	0	0	0 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	0	0	0	0	0 90.00
91.00 09100 EMERGENCY	0	0	0	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
200.00 Total (lines 50-199)	0	0	0	0	0 200.00

Cost Center Description	Title XIX			Hospital		Cost
	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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	42,763,497	0.000000	0.000000	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	43,711,222	0.000000	0.000000	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	53,056,589	0.000000	0.000000	0	55.00
56.00 05600 RADIOISOTOPE	0	4,796,693	0.000000	0.000000	0	56.00
57.00 05700 CT SCAN	0	72,293,932	0.000000	0.000000	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	12,345,730	0.000000	0.000000	0	58.00
60.00 06000 LABORATORY	0	60,263,380	0.000000	0.000000	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	6,914,391	0.000000	0.000000	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	25,074,759	0.000000	0.000000	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	2,119,949	0.000000	0.000000	0	65.00
66.00 06600 PHYSICAL THERAPY	0	1,998,003	0.000000	0.000000	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	4,794,789	0.000000	0.000000	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	28,348,975	0.000000	0.000000	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	580,451,939	0.000000	0.000000	0	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.01 03951 HOSPITAL NUTRITION	0	624,281	0.000000	0.000000	0	76.01
76.02 03952 PAIN MANAGEMENT	0	731,060	0.000000	0.000000	0	76.02
76.03 03954 INFUSION CENTER	0	0	0.000000	0.000000	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	4,535,860	0.000000	0.000000	0	90.00
91.00 09100 EMERGENCY	0	1,417,389	0.000000	0.000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	828,285	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	947,070,723			0	200.00

Cost Center Description	Title XIX			Hospital		PSA Adj. Nursing School	Cost
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Anesthetist Cost	PSA Adj. Nursing School		
	11.00	12.00	13.00	21.00	22.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	76.00
76.01 03951 HOSPITAL NUTRITION	0	0	0	0	0	0	76.01
76.02 03952 PAIN MANAGEMENT	0	0	0	0	0	0	76.02
76.03 03954 INFUSION CENTER	0	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	200.00

Cost Center Description		Title XIX		Hospital	Cost
		PSA Adj. Allied Health 23.00	PSA Adj. All Other Medical Education Cost 24.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	0		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600 RADIOISOTOPE	0	0		56.00
57.00	05700 CT SCAN	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000 LABORATORY	0	0		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400 INTRAVENOUS THERAPY	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.01	03951 HOSPITAL NUTRITION	0	0		76.01
76.02	03952 PAIN MANAGEMENT	0	0		76.02
76.03	03954 INFUSION CENTER	0	0		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0	0		90.00
91.00	09100 EMERGENCY	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

	Title XVIII	Hospital	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)	12,739	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,739	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)	12,035	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)	1,550	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	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)	20,650,048	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)	20,650,048	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	0	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)	18,069,574	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	18,069,574	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.142808	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,501.42	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)	20,650,048	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)	1,621.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,512,566	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)	2,512,566	41.00

Cost Center Description	Title XVIII			Hospital	PPS		42.00
	Total	Total	Average Per	Program Days	Program Cost		
	Inpatient Cost	Inpatient Days	Diem (col. 1 + col. 2)		(col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	4,704,546	639	7,362.36	135	993,919		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT	2,329,458	459	5,075.07	82	416,156		46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
<b>Cost Center Description</b>					1.00		
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					5,753,370		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					9,676,011		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					394,633		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					376,645		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					771,278		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					8,904,733		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE-SWING BED COST</b>							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)					704		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,621.01		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,141,191		89.00

Cost Center Description	Cost	Title XVIII		Hospital	PPS	
		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	
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
90.00 Capital-related cost	2,305,814	20,650,048	0.111661	1,141,191	127,427	90.00
91.00 Nursing school cost	0	20,650,048	0.000000	1,141,191	0	91.00
92.00 Allied health cost	0	20,650,048	0.000000	1,141,191	0	92.00
93.00 All other Medical Education	0	20,650,048	0.000000	1,141,191	0	93.00

Title XIX		Hospital	Cost
Cost Center Description			1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>			
<b>INPATIENT DAYS</b>			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,739	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,739	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)	12,035	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)	19	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
<b>SWING BED ADJUSTMENT</b>			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	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)	20,650,048	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)	20,650,048	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	0	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>			
28.00	General inpatient routine service charges (excluding swing-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)	0.000000	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.00	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	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	20,650,048	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	0	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>			
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,621.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	30,799	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)	30,799	41.00

Cost Center Description	Title XIX			Hospital		Cost
	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
42.00 NURSERY (title v & XIX only)						
Intensive Care Type Inpatient Hospital Units					36,812	43.00
43.00 INTENSIVE CARE UNIT	4,704,546	639	7,362.36	5		44.00
44.00 CORONARY CARE UNIT						45.00
45.00 BURN INTENSIVE CARE UNIT						46.00
46.00 SURGICAL INTENSIVE CARE UNIT	2,329,458	459	5,075.07	0	0	47.00
47.00 OTHER SPECIAL CARE (SPECIFY)						
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					67,611	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>						
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
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
54.00 Program discharges					0.00	54.00
55.00 Target amount per discharge					0	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)					0.00	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	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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>						
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
87.00 Total observation bed days (see instructions)					704	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,621.01	88.00
89.00 observation bed cost (line 87 x line 88) (see instructions)					1,141,191	89.00

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet D-3

Date/Time Prepared:  
11/23/2012 3:41 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)		
		1.00	2.00	3.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		2,157,170				30.00
31.00	03100 INTENSIVE CARE UNIT		416,466				31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		177,682				34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.260927	1,804,606	470,870			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.204938	350,922	71,917			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.237727	938,145	223,022			55.00
56.00	05600 RADIOISOTOPE	0.190048	97,787	18,584			56.00
57.00	05700 CT SCAN	0.038857	726,935	28,247			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.116985	221,045	25,859			58.00
60.00	06000 LABORATORY	0.187036	1,925,260	360,093			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.358738	954,758	342,508			63.00
64.00	06400 INTRAVENOUS THERAPY	0.253264	69,473	17,595			64.00
65.00	06500 RESPIRATORY THERAPY	0.822581	363,088	298,669			65.00
66.00	06600 PHYSICAL THERAPY	0.984015	199,498	196,309			66.00
69.00	06900 ELECTROCARDIOLOGY	0.204220	265,517	54,224			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.635169	1,830,285	1,162,540			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.201918	10,072,833	2,033,886			73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0			76.00
76.01	03951 HOSPITAL NUTRITION	3.007146	2,786	8,378			76.01
76.02	03952 PAIN MANAGEMENT	1.602377	9,239	14,804			76.02
76.03	03954 INFUSION CENTER	0.000000	0	0			76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	2.894312	120,641	349,173			90.00
91.00	09100 EMERGENCY	2.758799	27,799	76,692			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.377776	0	0			92.00
200.00	Total (sum of lines 50-94 and 96-98)		19,980,617	5,753,370			200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0			201.00
202.00	Net Charges (line 200 minus line 201)		19,980,617				202.00

Title XVIII		Hospital	PPS
		before 1/1	on/after 1/1
		1.00	1.01
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>		1,979,010	1.00
1.00	DRG Amounts Other than Outlier Payments	5,406,162	2.00
2.00	Outlier payments for discharges. (see instructions)	0	2.01
2.01	For inpatient PPS services rendered during the cost reporting period enter the operating outlier reconciliation amount for operating expenses from line 92.	0	3.00
3.00	Managed Care Simulated Payments	65.50	4.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		
<b>Indirect Medical Education Adjustment</b>		0.00	5.00
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	6.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	7.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.01
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	8.00
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.	0.00	8.01
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.02
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	9.00
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)	0.00	10.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	11.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	12.00
12.00	Current year allowable FTE (see instructions)	0.00	13.00
13.00	Total allowable FTE count for the prior year.	0.00	14.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	15.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	16.00
16.00	Adjustment for residents in initial years of the program	0.00	17.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	18.00
18.00	Adjusted rolling average FTE count	0.000000	19.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	20.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	21.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0	22.00
22.00	IME payment adjustment (see instructions)		
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>		0.00	23.00
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C ).	0.00	24.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	25.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.000000	26.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	27.00
27.00	IME payments adjustment. (see instructions)	0	28.00
28.00	IME Adjustment (see instructions)	0	29.00
29.00	Total IME payment ( sum of lines 22 and 28)		
<b>Disproportionate Share Adjustment</b>		0.00	30.00
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.00	31.00
31.00	Percentage of Medicaid patient days to total days reported on worksheet S-2, Part I, line 24. (see instructions)	0.00	32.00
32.00	Sum of lines 30 and 31	0.00	33.00
33.00	Allowable disproportionate share percentage (see instructions)	0	34.00
34.00	Disproportionate share adjustment (see instructions)		
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>		0	40.00
40.00	Total Medicare discharges on worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0	41.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0.00	42.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0	43.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0.000000	44.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.00	0.00 45.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0	46.00
46.00	Total additional payment (line 45 times line 44 times line 41)	7,385,172	47.00
47.00	Subtotal (see instructions)		

	Title XVIII	Hospital		PPS
		before 1/1	on/after 1/1	
		1.00	1.01	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	7,385,172		49.00
50.00	Payment for inpatient program capital (from worksheet L, Parts I, II, as applicable)	521,984		50.00
51.00	Exception payment for inpatient program capital (worksheet L, Part III, see instructions)	0		51.00
52.00	Direct graduate medical education payment (from worksheet E-4, line 49 see instructions).	0		52.00
53.00	Nursing and Allied Health Managed Care payment	0		53.00
54.00	Special add-on payments for new technologies	0		54.00
55.00	Net organ acquisition cost (worksheet D-4 Part III, col. 1, line 69)	0		55.00
56.00	Cost of teaching physicians (worksheet D-5, Part II, col. 3, line 20)	0		56.00
57.00	Routine service other pass through costs	0		57.00
58.00	Ancillary service other pass through costs worksheet D, Part IV, col. 11 line 200)	0		58.00
59.00	Total (sum of amounts on lines 49 through 58)	7,907,156		59.00
60.00	Primary payer payments	4,787		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	7,902,369		61.00
62.00	Deductibles billed to program beneficiaries	138,172		62.00
63.00	Coinsurance billed to program beneficiaries	76,384		63.00
64.00	Allowable bad debts (see instructions)	13,524		64.00
65.00	Adjusted reimbursable bad debts (see instructions)	9,467		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	7,697,280		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)	0		68.00
69.00	Enter the time value of money for operating expenses, the capital outlier reconciliation amount and time value of money for capital related expenses by entering the sum of lines 93, 95 and 96. For SCH, if the hospital specific payment amount on line 48, is greater than the federal specific payment amount on line 47, do not complete this line.	0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		70.00
70.95	Recovery of Accelerated Depreciation	0		70.95
70.96	Low Volume Payment-1	0		70.96
70.97	Low volume Payment-2	0		70.97
70.98	Low volume Payment-3	0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	7,697,280		71.00
72.00	Interim payments	7,694,826		72.00
73.00	Tentative settlement (for contractor use only)	0		73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)	2,454		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0		75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Operating outlier amount from worksheet E, Part A line 2	0		90.00
91.00	Capital outlier from worksheet L, Part I, line 2	0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)	0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)	0		93.00
94.00	The rate used to calculate the Time value of Money	0.00		94.00
95.00	Time value of Money for operating expenses(see instructions)	0		95.00
96.00	Time value of Money for capital related expenses (see instructions)	0		96.00

Title XVIII		Hospital	PPS	
			1.00	
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		8,682	1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)		15,967,819	2.00
3.00	PPS payments		10,713,439	3.00
4.00	Outlier payment (see instructions)		291,407	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.426	5.00
6.00	Line 2 times line 5		6,802,291	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)		8,682	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		35,248	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)		35,248	14.00
<b>Customary charges</b>				
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)		35,248	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		26,566	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)		8,682	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		11,004,846	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,044,568	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)		8,968,960	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)		8,968,960	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		8,968,960	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		257,814	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		180,470	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		9,149,430	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		9,149,430	40.00
41.00	Interim payments		9,096,908	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		52,522	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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

Health Financial Systems  
CALCULATION OF REIMBURSEMENT SETTLEMENT

MIDWESTERN REGIONAL MEDICAL CENTER

In Lieu of Form CMS-2552-10

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet E  
Part B  
Date/Time Prepared:  
11/23/2012 3:41 pm

Title XVIII

Hospital

PPS

Overrides

1.00

0.112.00

**WORKSHEET OVERRIDE VALUES**

112.00 Override of Ancillary service charges (line 12)

		Title XVIII		Hospital		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		7,693,547		9,072,522	1.00	2.00	
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			
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	
<b>Program to Provider</b>								
3.01	ADJUSTMENTS TO PROVIDER	04/01/2012	1,279		24,386	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	
<b>Provider to Program</b>								
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)		1,279		24,386	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)		7,694,826		9,096,908	4.00		
<b>TO BE COMPLETED BY CONTRACTOR</b>								
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	
<b>Program to Provider</b>								
5.01	TENTATIVE TO PROVIDER		0		0	5.01		
5.02			0		0		5.02	
5.03			0		0		5.03	
<b>Provider to Program</b>								
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)		2,454		52,522	6.00		
6.01	SETTLEMENT TO PROVIDER		0		0	6.01		
6.02	SETTLEMENT TO PROGRAM		7,697,280		9,149,430	6.02		
7.00	Total Medicare program liability (see instructions)					7.00		
				Contractor Number	Date (Mo/Day/Yr)			
			0	1.00	2.00			
8.00	Name of Contractor							8.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

worksheet G

Date/Time Prepared:  
11/23/2012 3:41 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>					
1.00 Cash on hand in banks	0	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	0	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	0	0	0	0	7.00
8.00 Prepaid expenses	0	0	0	0	8.00
9.00 other current assets	0	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	0	0	0	0	11.00
<b>FIXED ASSETS</b>					
12.00 Land	0	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	0	0	0	0	15.00
16.00 Accumulated depreciation	0	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	0	0	0	0	23.00
24.00 Accumulated depreciation	0	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	0	0	0	0	27.00
28.00 Accumulated depreciation	0	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)	0	0	0	0	30.00
<b>OTHER ASSETS</b>					
31.00 Investments	0	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	0	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	0	0	0	0	36.00
<b>CURRENT LIABILITIES</b>					
37.00 Accounts payable	0	0	0	0	37.00
38.00 Salaries, wages, and fees payable	0	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	0	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	0	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	0	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	0	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>					
52.00 General fund balance	0	0	0	0	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)	0	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	0	0	0	0	60.00

Health Financial Systems  
STATEMENT OF CHANGES IN FUND BALANCES

MIDWESTERN REGIONAL MEDICAL CENTER

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

In Lieu of Form CMS-2552-10

Worksheet G-1

Date/Time Prepared:  
11/23/2012 3:41 pm

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
1.00 Fund balances at beginning of period		0		0	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		-565,198,032		0	2.00
3.00 Total (sum of line 1 and line 2)		-565,198,032			3.00
4.00 Additions (credit adjustments) (specify)	0		0		4.00
5.00	0		0		5.00
6.00	0		0		6.00
7.00	0		0		7.00
8.00	0		0		8.00
9.00	0		0		9.00
9.00 Total additions (sum of line 4-9)		0		0	10.00
10.00 Subtotal (line 3 plus line 10)		-565,198,032		0	11.00
11.00 Deductions (debit adjustments) (specify)	0		0		12.00
12.00	0		0		13.00
13.00	0		0		14.00
14.00	0		0		15.00
15.00	0		0		16.00
16.00	0		0		17.00
17.00	0		0		18.00
17.00 Total deductions (sum of lines 12-17)		0		0	19.00
18.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		-565,198,032		0	

Health Financial Systems  
STATEMENT OF CHANGES IN FUND BALANCES

MIDWESTERN REGIONAL MEDICAL CENTER

Provider CCN: 140100

Period:  
From 07/01/2011  
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In Lieu of Form CMS-2552-10

Worksheet G-1

Date/Time Prepared:  
11/23/2012 3:41 pm

	Endowment Fund		Plant Fund		
	5.00	6.00	7.00	8.00	
1.00 Fund balances at beginning of period			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		3.00
4.00 Additions (credit adjustments) (specify)	0			0	4.00
5.00	0			0	5.00
6.00	0			0	6.00
7.00	0			0	7.00
8.00	0			0	8.00
9.00	0			0	9.00
10.00 Total additions (sum of line 4-9)			0		10.00
11.00 Subtotal (line 3 plus line 10)			0		11.00
12.00 Deductions (debit adjustments) (specify)	0			0	12.00
13.00	0			0	13.00
14.00	0			0	14.00
15.00	0			0	15.00
16.00	0			0	16.00
17.00	0			0	17.00
18.00 Total deductions (sum of lines 12-17)			0		18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)			0		19.00

Cost Center Description	Inpatient	Outpatient	Total	
	1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>				
<b>General Inpatient Routine Services</b>				
1.00 Hospital	0		0	1.00
2.00 SUBPROVIDER - IPF				2.00
3.00 SUBPROVIDER - IRF				3.00
4.00 SUBPROVIDER				4.00
5.00 Swing bed - SNF	0		0	5.00
6.00 Swing bed - NF	0		0	6.00
7.00 SKILLED NURSING FACILITY				7.00
8.00 NURSING FACILITY				8.00
9.00 OTHER LONG TERM CARE				9.00
10.00 Total general inpatient care services (sum of lines 1-9)	0		0	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>				
11.00 INTENSIVE CARE UNIT	0		0	11.00
12.00 CORONARY CARE UNIT				12.00
13.00 BURN INTENSIVE CARE UNIT	0		0	13.00
14.00 SURGICAL INTENSIVE CARE UNIT				14.00
15.00 OTHER SPECIAL CARE (SPECIFY)	0		0	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)	0	0	0	17.00
18.00 Ancillary services	0	0	0	18.00
19.00 Outpatient services	0	0	0	19.00
20.00 RURAL HEALTH CLINIC	0	0	0	20.00
21.00 FEDERALLY QUALIFIED HEALTH CENTER				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	0	0	0	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)	0	0	0	28.00
<b>PART II - OPERATING EXPENSES</b>				
29.00 Operating expenses (per wkst. A, column 3, line 200)		565,198,032		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	0	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)		565,198,032		43.00

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	0	1.00
2.00	Less contractual allowances and discounts on patients' accounts	0	2.00
3.00	Net patient revenues (line 1 minus line 2)	0	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	565,198,032	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-565,198,032	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	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	0	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	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	-565,198,032	25.00
26.00	Total (line 5 plus line 25)	0	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-565,198,032	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)		29.00

Provider CCN: 140100

Period:  
From 07/01/2011  
To 06/30/2012

Worksheet L  
Parts I-III  
Date/Time Prepared:  
11/23/2012 3:41 pm

Title XVIII

Hospital

PPS

1.00

**PART I - FULLY PROSPECTIVE METHOD**

**CAPITAL FEDERAL AMOUNT**

1.00	Capital DRG other than outlier	160,328	1.00
2.00	Capital DRG outlier payments	361,656	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	35.88	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)	0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)	521,984	12.00
		1.00	

**PART II - PAYMENT UNDER REASONABLE COST**

1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	

**PART III - COMPUTATION OF EXCEPTION PAYMENTS**

1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

		1.00	
		20,650,048	1.00
1.00	Total general inpatient routine service cost.	13,133	2.00
2.00	Total inpatient days.	1,572.38	3.00
3.00	Cost per day.	0	4.00
4.00	Percentage (93% = Short Term; 98% = Long Term).	0.00	5.00
5.00	Reduced cost per day.	0	6.00
6.00	Ancillary percentage.	0.00	7.00
7.00	Ancillary cost per day.	0	8.00
8.00	Inpatient Part B days.	0	9.00
9.00	Total Part B ancillary cost.		