

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).  
 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

FORM APPROVED  
 OMB NO. 0938-0050  
 Worksheet S  
 Parts I-III  
 Date/Time Prepared:  
 10/29/2012 11:53 am

Provider CCN: I44034  
 Period:  
 From 07/01/2011  
 To 06/30/2012

**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.

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 STREAMWOOD 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) Dan L. Mullins  
 Officer or Administrator of Provider(s)  
 Vice President of Reimbursement  
 Title  
 10-30-12  
 Date

Cost Center Description	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	0	0	0	116,366	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	0	0	0	116,366	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144034	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 10/29/2012 11:53 am
---	--	----------------------	---	---

		1.00	2.00	3.00	4.00						
<b>Hospital and Hospital Health Care Complex Address:</b>											
1.00	Street: 1400 EAST IRVING PARK	PO Box:		Zip Code: 60107	County: COOK			1.00			
2.00	City: STREAMWOOD	State: IL					2.00				
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
							V	XVIII	XIX		
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
<b>Hospital and Hospital-Based Component Identification:</b>											
3.00	Hospital	STREAMWOOD	144034	16974	4	05/01/1991	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						N	N	N	7.00	
8.00	Swing Beds - NF						N		N	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:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2011	06/30/2012		20.00	
21.00	Type of Control (see instructions)						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.						3		N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible 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		
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		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 144034	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 10/29/2012 11:53 am
---	----------------------	---	---

		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)	N	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		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 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	0.000000	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 144034

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
10/29/2012 11:53 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
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	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 144034

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
10/29/2012 11:53 am

		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.	Y			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)	N	N	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	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
<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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144034	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 10/29/2012 11:53 am
---	--	----------------------	---	---

		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.	N			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.	0			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.	0	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	399001		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: UNIVERSAL HEALTH SERVICES	Contractor's Name: 399001		Contractor's Number: 399001	141.00
142.00	Street: 367 SOUTH GULPH ROAD	PO Box:			142.00
143.00	City: KING OF PRUSSIA	State: PA	Zip Code: 19406		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: 144034

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
10/29/2012 11:53 am

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

					1.00	
--	--	--	--	--	------	--

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

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

							1.00	
--	--	--	--	--	--	--	------	--

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						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)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 144034	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part II Date/Time Prepared: 10/29/2012 11:53 am
---	----------------------	---	--

	Y/N	Date	
	1.00	2.00	

General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

Provider Organization and Operation

1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
------	--	---	--	--	------

	Y/N	Date	V/I	
	1.00	2.00	3.00	

2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
------	---	---	--	--	------

3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
------	--	---	--	--	------

	Y/N	Type	Date	
	1.00	2.00	3.00	

Financial Data and Reports

4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
------	--	---	---	--	------

5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
------	--	---	--	--	------

	Y/N	Legal Oper.	
	1.00	2.00	

Approved Educational Activities

6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
------	---	---	--	--	------

7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
------	--	---	--	--	------

8.00	were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
------	---	---	--	--	------

9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
------	--	---	--	--	------

10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
-------	--	---	--	--	-------

11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N			11.00
-------	---	---	--	--	-------

	Y/N		
	1.00		

Bad Debts

12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	N			12.00
-------	--	---	--	--	-------

13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
-------	---	---	--	--	-------

14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
-------	--	---	--	--	-------

Bed Complement

15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
-------	---	---	--	--	-------

	Description	Part A		
		Y/N	Date	
	0	1.00	2.00	

PS&R Data

16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/26/2012		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		
		0	1.00		
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N			21.00
				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	N			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N			25.00
26.00	were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N			27.00
<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.	Y			34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N			35.00
				Y/N	Date
				1.00	2.00
<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.	Y	12/31/2011		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.	KEVIN		SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	UHS, INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-312-5742		KEVIN.SMITH@UHSINC.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	10/26/2012	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.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 144034

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
10/29/2012 11:53 am

Cost Center Description	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	
	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	172	62,952	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)		172	62,952	0.00	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)		172	62,952	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	46.00	2	465		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)		174			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 144034

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
10/29/2012 11:53 am

Cost Center Description	I/P Days / O/P Visits / Trips				Total All Patients	
	Title V	Title XVIII	Title XIX			
	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	0	26,327	40,446		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	0	26,327	40,446		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	0	26,327	40,446		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				459		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		0	0		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 144034

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
10/29/2012 11:53 am

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	0	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						4.00
4.00 HMO IRF						5.00
5.00 Hospital Adults & Peds. Swing Bed SNF						6.00
6.00 Hospital Adults & Peds. Swing Bed NF						7.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						8.00
8.00 INTENSIVE CARE UNIT						9.00
9.00 CORONARY CARE UNIT						10.00
10.00 BURN INTENSIVE CARE UNIT						11.00
11.00 SURGICAL INTENSIVE CARE UNIT						12.00
12.00 OTHER SPECIAL CARE (SPECIFY)						13.00
13.00 NURSERY						14.00
14.00 Total (see instructions)	0.00	292.00	0.00	0	0	15.00
15.00 CAH visits						16.00
16.00 SUBPROVIDER - IPF						17.00
17.00 SUBPROVIDER - IRF						18.00
18.00 SUBPROVIDER						19.00
19.00 SKILLED NURSING FACILITY						20.00
20.00 NURSING FACILITY						21.00
21.00 OTHER LONG TERM CARE	0.00	27.00	0.00			22.00
22.00 HOME HEALTH AGENCY						23.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						24.00
24.00 HOSPICE						25.00
25.00 CMHC - CMHC						26.00
26.00 RURAL HEALTH CLINIC						26.25
26.25 FEDERALLY QUALIFIED HEALTH CENTER						27.00
27.00 Total (sum of lines 14-26)	0.00	319.00	0.00			28.00
28.00 Observation Bed Days						29.00
29.00 Ambulance Trips						30.00
30.00 Employee discount days (see instruction)						31.00
31.00 Employee discount days - IRF						32.00
32.00 Labor & delivery days (see instructions)						33.00
33.00 LTCH non-covered days						

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)	2,197	2,650	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)	2,197	2,650	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		14	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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 144034

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

Worksheet S-10

Date/Time Prepared:  
10/29/2012 11:53 am

		1.00			
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)	0.332646	1.00		
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid	0	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00		
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00		
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00		
6.00	Medicaid charges	0	6.00		
7.00	Medicaid cost (line 1 times line 6)	0	7.00		
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00		
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone SCHIP	0	9.00		
10.00	Stand-alone SCHIP charges	0	10.00		
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00		
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00		
<b>Other state or local government indigent care program (see instructions for each line)</b>					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00		
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00		
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00		
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00		
<b>Uncompensated care (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00		
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00		
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00		
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	0	0	0	0 20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0	0 21.00
22.00	Partial payment by patients approved for charity care	0	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	0	0	0	0 23.00
					1.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	0		0 25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	0	0		0 26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	0	0		0 27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	0	0		0 28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	0	0		0 29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	0	0		0 30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	0	0		0 31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144034

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

Worksheet A

Date/Time Prepared:  
10/29/2012 11:53 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (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		1,553,681		1,553,681	184,696	1,738,377	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		317,299		317,299	99,794	417,093	2.00
3.00	00300	OTHER CAP REL COSTS		0		0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	471,607	3,053,061		3,524,668	0	3,524,668	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,015,371	4,641,028		6,656,399	-481,361	6,175,038	5.00
7.00	00700	OPERATION OF PLANT	0	1,084,910		1,084,910	-4,221	1,080,689	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	170,371		170,371	0	170,371	8.00
9.00	00900	HOUSEKEEPING	0	494,682		494,682	0	494,682	9.00
10.00	01000	DIETARY	313,620	380,973		694,593	0	694,593	10.00
13.00	01300	NURSING ADMINISTRATION	1,030,881	10,529		1,041,410	0	1,041,410	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	229,726	150,579		380,305	0	380,305	16.00
17.00	01700	SOCIAL SERVICE	998,218	6,581		1,004,799	-1,004,799	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	6,158,424	2,786,856		8,945,280	1,384,421	10,329,701	30.00
46.00	04600	OTHER LONG TERM CARE	173,363	11,135		184,498	-95,246	89,252	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		0	0	0	54.00
60.00	06000	LABORATORY	0	80,924		80,924	0	80,924	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	38,626	96,965		135,591	-38,626	96,965	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	56,680	24,197		80,877	-68,263	12,614	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	761,432		761,432	0	761,432	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>									
90.00	09000	CLINIC	980,287	141,201		1,121,488	23,605	1,145,093	90.00
91.00	09100	EMERGENCY	0	0		0	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>									
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,466,803	15,766,404		28,233,207	0	28,233,207	118.00
<b>NONREIMBURSABLE COST CENTERS</b>									
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		0	0	0	194.00
194.01	07951	EDUCATION	297,320	3,020		300,340	0	300,340	194.01
194.02	07952	MARKETING	266,056	53,586		319,642	0	319,642	194.02
200.00		TOTAL (SUM OF LINES 118-199)	13,030,179	15,823,010		28,853,189	0	28,853,189	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144034

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

Worksheet A  
Date/Time Prepared:  
10/29/2012 11:53 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-49,254	1,689,123	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-4,010	413,083	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	-617,025	2,907,643	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,471,134	3,703,904	5.00
7.00	00700	OPERATION OF PLANT	0	1,080,689	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	170,371	8.00
9.00	00900	HOUSEKEEPING	0	494,682	9.00
10.00	01000	DIETARY	-6,589	688,004	10.00
13.00	01300	NURSING ADMINISTRATION	0	1,041,410	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-14,491	365,814	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-2,847,787	7,481,914	30.00
46.00	04600	OTHER LONG TERM CARE	-719	88,533	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	80,924	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	-96,965	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-12,614	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	761,432	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	-764,953	380,140	90.00
91.00	09100	EMERGENCY	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00	SUBTOTALS (SUM OF LINES 1-117)		-6,885,541	21,347,666	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	EDUCATION	0	300,340	194.01
194.02	07952	MARKETING	0	319,642	194.02
200.00	TOTAL (SUM OF LINES 118-199)		-6,885,541	21,967,648	200.00

Provider CCN: 144034

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

worksheet A-6  
Date/Time Prepared:  
10/29/2012 11:53 am

		Increases			
Cost Center		Line #	salary	other	
2.00		3.00	4.00	5.00	
<b>B - RENT LEASE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	184,696	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	99,794	2.00
3.00		0.00	0	0	3.00
	<b>TOTALS</b>		0	284,490	
<b>C - RECREATION THERAPY</b>					
1.00	ADULTS & PEDIATRICS	30.00	173,047	2,448	1.00
2.00	OTHER LONG TERM CARE	46.00	1,964	28	2.00
	<b>TOTALS</b>		175,011	2,476	
<b>D - TRANSPORTATION</b>					
1.00	CLINIC	90.00	22,764	841	1.00
	<b>TOTALS</b>		22,764	841	
<b>E - THERAPY</b>					
1.00	ADULTS & PEDIATRICS	30.00	1,089,199	12,838	1.00
2.00	OTHER LONG TERM CARE	46.00	12,361	146	2.00
	<b>TOTALS</b>		1,101,560	12,984	
<b>F - ANCILLARIES</b>					
1.00	ADULTS & PEDIATRICS	30.00	95,306	11,583	1.00
2.00		0.00	0	0	2.00
	<b>TOTALS</b>		95,306	11,583	
500.00	<b>Grand Total: Increases</b>		1,394,641	312,374	500.00

		Decreases				wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
<b>B - RENT LEASE</b>							
1.00		0.00	0	0	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	280,269	10		2.00
3.00	OPERATION OF PLANT	7.00	0	4,221	0		3.00
TOTALS			0	284,490			
<b>C - RECREATION THERAPY</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	175,011	2,476	0		1.00
2.00		0.00	0	0	0		2.00
TOTALS			175,011	2,476			
<b>D - TRANSPORTATION</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	22,764	841	0		1.00
TOTALS			22,764	841			
<b>E - THERAPY</b>							
1.00	SOCIAL SERVICE	17.00	998,218	6,581	0		1.00
2.00	OTHER LONG TERM CARE	46.00	103,342	6,403	0		2.00
TOTALS			1,101,560	12,984			
<b>F - ANCILLARIES</b>							
1.00	ELECTROCARDIOLOGY	69.00	38,626	0	0		1.00
2.00	ELECTROENCEPHALOGRAPHY	70.00	56,680	11,583	0		2.00
TOTALS			95,306	11,583			
500.00	Grand Total: Decreases		1,394,641	312,374			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144034

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
10/29/2012 11:53 am

	Beginning Balances 1.00	Acquisitions			Disposals and Retirements 5.00		
		Purchases 2.00	Donation 3.00	Total 4.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	2,240,512	0	0	0	1.00	
2.00	Land Improvements	0	0	0	0	2.00	
3.00	Buildings and Fixtures	19,349,308	0	0	0	3.00	
4.00	Building Improvements	412,122	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	5.00	
6.00	Movable Equipment	2,006,845	0	0	0	6.00	
7.00	HIT designated Assets	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	24,008,787	0	0	0	8.00	
9.00	Reconciling Items	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	24,008,787	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	803,291	0	0	51,257	699,133	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	293,743	0	0	23,556	0	2.00
3.00	Total (sum of lines 1-2)	1,097,034	0	0	74,813	699,133	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	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144034

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
10/29/2012 11:53 am

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	2,240,512	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	19,349,308	0			3.00
4.00	Building Improvements	412,122	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	2,006,845	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	24,008,787	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	24,008,787	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	1,553,681			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	317,299			2.00
3.00	Total (sum of lines 1-2)	0	1,870,980			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	754,037	184,696 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	289,733	99,794 2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,043,770	284,490 3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144034

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
10/29/2012 11:53 am

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	0	51,257	699,133	0	1,689,123	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	23,556	0	0	413,083	2.00
3.00	Total (sum of lines 1-2)	0	74,813	699,133	0	2,102,206	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted	
			Line #	
			3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	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)	A	✓ -118,370	ADMINISTRATIVE & GENERAL	5.00 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	✓ -3,634,540		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	✓ -2,636,744		12.00
13.00 Laundry and linen service		0		0.00 13.00
14.00 Cafeteria-employees and guests	A	✓ -4,485	DIETARY	10.00 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	A	✓ -14,491	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00 Vending machines	A	✓ -2,104	DIETARY	10.00 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	*** Cost Center Deleted ***	65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	B	✓ -49,254	CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	B	✓ -4,010	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	OCCUPATIONAL THERAPY	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 PHYSICIAN COSTS	B	✓ -44,576	ADULTS & PEDIATRICS	30.00 33.00
34.00 PHYSICIAN COSTS	B	✓ -17,816	CLINIC	90.00 34.00
35.00 PHYSICIAN COSTS	B	✓ -204,858	EMPLOYEE BENEFITS	4.00 35.00
36.00 MISC REVENUE	A	✓ -8,452	ADMINISTRATIVE & GENERAL	5.00 36.00
37.00 PT TRANSPORTATION	B	✓ -29,630	ADMINISTRATIVE & GENERAL	5.00 37.00
38.00 PT TRANSPORTATION	B	✓ -25,322	ADULTS & PEDIATRICS	30.00 38.00
39.00 PT TRANSPORTATION	B	✓ -719	OTHER LONG TERM CARE	46.00 39.00
40.00 PT TRANSPORTATION	B	✓ -65	CLINIC	90.00 40.00
41.00 REBATES OFFSET FOR INFO ONLY	A	118,370	ADMINISTRATIVE & GENERAL	5.00 41.00
42.00		0		0.00 42.00
43.00		0		0.00 43.00
44.00 DONATIONS	B	✓ -19,803	ADMINISTRATIVE & GENERAL	5.00 44.00
45.00 PHYSICIAN BILLING	B	✓ -94,501	ADMINISTRATIVE & GENERAL	5.00 45.00
46.00 PHYSICIAN RECRUITING	B	✓ -2,894	ADMINISTRATIVE & GENERAL	5.00 46.00
47.00 LOBBYING	B	✓ -13,314	ADMINISTRATIVE & GENERAL	5.00 47.00
48.00 BAD DEBT	B	✓ -77,963	ADMINISTRATIVE & GENERAL	5.00 48.00
49.00		0		0.00 49.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-6,885,541		50.00

Cost Center Description	5.00	Ref.	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0		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 PHYSICIAN COSTS	0		33.00
34.00 PHYSICIAN COSTS	0		34.00
35.00 PHYSICIAN COSTS	0		35.00
36.00 MISC REVENUE	0		36.00
37.00 PT TRANSPORTATION	0		37.00
38.00 PT TRANSPORTATION	0		38.00
39.00 PT TRANSPORTATION	0		39.00
40.00 PT TRANSPORTATION	0		40.00
41.00 REBATES OFFSET FOR INFO ONLY	0		41.00
42.00	0		42.00
43.00	0		43.00
44.00 DONATIONS	0		44.00
45.00 PHYSICIAN BILLING	0		45.00
46.00 PHYSICIAN RECRUITING	0		46.00
47.00 LOBBYING	0		47.00
48.00 BAD DEBT	0		48.00
49.00	0		49.00
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: 144034

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

worksheet A-8-1

Date/Time Prepared:  
10/29/2012 11:53 am

		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 FEE	1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY INTEREST	2.00
3.00		4.00	EMPLOYEE BENEFITS	WORKERS COMP INSURANCE	3.00
4.00		5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE INSURANCE	4.00
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		B		0.00	6.00
7.00				0.00	7.00
8.00				0.00	8.00
9.00				0.00	9.00
10.00				0.00	10.00
100.00	G. other (financial or non-financial) specify:				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS  
 Provider CCN: 144034  
 Period: From 07/01/2011 To 06/30/2012  
 Worksheet A-8-1  
 Date/Time Prepared: 10/29/2012 11:53 am

	Amount of Allowable Cost	Amount Included in wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	4.00	5.00	6.00	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	971,963	772,836	199,127	0	1.00
2.00	0	2,110,036	-2,110,036	0	2.00
3.00	125,492	537,659	-412,167	0	3.00
4.00	44,290	357,958	-313,668	0	4.00
5.00	1,141,745	3,778,489	-2,636,744		5.00
TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.					

\* 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	UNIVERSAL HEALT	100.00	HOSPITAL	6.00
7.00		0.00		7.00
8.00		0.00		8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144034

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

worksheet A-8-2

Date/Time Prepared:  
10/29/2012 11:53 am

	1.00	2.00	3.00	4.00	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	2,777,889	2,777,889	1.00
2.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	12,614	12,614	2.00
3.00	90.00	AGGREGATE-CLINIC	747,072	747,072	3.00
4.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	96,965	96,965	4.00
5.00	0.00		0	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			3,634,540	3,634,540	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144034

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

Worksheet A-8-2

Date/Time Prepared:  
10/29/2012 11:53 am

	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	0	0	0	0	0	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	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144034

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

Worksheet A-8-2

Date/Time Prepared:  
10/29/2012 11:53 am

	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	
	12.00	13.00	14.00	15.00	16.00	
1.00	0	0	0	0	0	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	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144034

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

worksheet A-8-2

Date/Time Prepared:  
10/29/2012 11:53 am

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	2,777,889	1.00
2.00	0	12,614	2.00
3.00	0	747,072	3.00
4.00	0	96,965	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	3,634,540	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:144034

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

Worksheet B  
Part I  
Date/Time Prepared:  
10/29/2012 11:53 am

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	2.00	4.00	4A			
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,689,123	1,689,123			1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP	413,083		413,083		2.00	
4.00	00400	EMPLOYEE BENEFITS	2,907,643	0	0	2,907,643	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	3,703,904	363,204	88,823	420,823	4,576,754	5.00
7.00	00700	OPERATION OF PLANT	1,080,689	117,600	28,760	0	1,227,049	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	170,371	24,211	5,921	0	200,503	8.00
9.00	00900	HOUSEKEEPING	494,682	11,562	2,827	0	509,071	9.00
10.00	01000	DIETARY	688,004	96,108	23,504	72,611	880,227	10.00
13.00	01300	NURSING ADMINISTRATION	1,041,410	14,018	3,428	238,677	1,297,533	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	365,814	13,457	3,291	53,188	435,750	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	7,481,914	958,224	234,337	1,740,146	10,414,621	30.00
46.00	04600	OTHER LONG TERM CARE	88,533	5,298	1,296	19,528	114,655	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	80,924	0	0	0	80,924	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	761,432	10,421	2,549	0	774,402	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	380,140	64,458	15,764	232,233	692,595	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,347,666	1,678,561	410,500	2,777,206	21,204,084	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	EDUCATION	300,340	9,632	2,356	68,838	381,166	194.01
194.02	07952	MARKETING	319,642	930	227	61,599	382,398	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	21,967,648	1,689,123	413,083	2,907,643	21,967,648	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144034

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

worksheet B  
Part I  
Date/Time Prepared:  
10/29/2012 11:53 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	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	4,576,754				5.00
7.00	00700	OPERATION OF PLANT	322,922	1,549,971			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	52,766	31,057	284,326		8.00
9.00	00900	HOUSEKEEPING	133,972	14,831	0	657,874	9.00
10.00	01000	DIETARY	231,649	123,283	0	53,923	1,289,082
13.00	01300	NURSING ADMINISTRATION	341,472	17,982	0	7,865	0
16.00	01600	MEDICAL RECORDS & LIBRARY	114,676	17,261	0	7,550	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	2,740,810	1,229,160	281,136	537,625	1,274,617
46.00	04600	OTHER LONG TERM CARE	30,174	6,797	3,190	2,973	14,465
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	21,297	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	203,799	13,368	0	5,847	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	182,270	82,684	0	36,165	0
91.00	09100	EMERGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,375,807	1,536,423	284,326	651,948	1,289,082
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	EDUCATION	100,311	12,355	0	5,404	0
194.02	07952	MARKETING	100,636	1,193	0	522	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	4,576,754	1,549,971	284,326	657,874	1,289,082

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144034

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

Worksheet B  
Part I  
Date/Time Prepared:  
10/29/2012 11:53 am

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	16.00	17.00	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
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
13.00	01300	NURSING ADMINISTRATION	1,664,852				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	575,237			16.00
17.00	01700	SOCIAL SERVICE	0	0	0		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,646,170	568,782	0	18,692,921	30.00
46.00	04600	OTHER LONG TERM CARE	18,682	6,455	0	197,391	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	102,221	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	997,416	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	993,714	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,664,852	575,237	0	20,983,663	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	EDUCATION	0	0	0	499,236	194.01
194.02	07952	MARKETING	0	0	0	484,749	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,664,852	575,237	0	21,967,648	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144034

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

Worksheet B  
Part I  
Date/Time Prepared:  
10/29/2012 11:53 am

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
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
13.00	01300 NURSING ADMINISTRATION		13.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS	18,692,921	30.00
46.00	04600 OTHER LONG TERM CARE	197,391	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000 LABORATORY	102,221	60.00
67.00	06700 OCCUPATIONAL THERAPY	0	67.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	997,416	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000 CLINIC	993,714	90.00
91.00	09100 EMERGENCY	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00	SUBTOTALS (SUM OF LINES 1-117)	20,983,663	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	07951 EDUCATION	499,236	194.01
194.02	07952 MARKETING	484,749	194.02
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	21,967,648	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144034

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

Worksheet B  
Part II  
Date/Time Prepared:  
10/29/2012 11:53 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
<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	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	48,552	363,204	88,823	500,579	5.00
7.00 00700	OPERATION OF PLANT	0	117,600	28,760	146,360	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	24,211	5,921	30,132	8.00
9.00 00900	HOUSEKEEPING	0	11,562	2,827	14,389	9.00
10.00 01000	DIETARY	0	96,108	23,504	119,612	10.00
13.00 01300	NURSING ADMINISTRATION	0	14,018	3,428	17,446	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	13,457	3,291	16,748	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	958,224	234,337	1,192,561	30.00
46.00 04600	OTHER LONG TERM CARE	0	5,298	1,296	6,594	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	10,421	2,549	12,970	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	64,458	15,764	80,222	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	48,552	1,678,561	410,500	2,137,613	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07951	EDUCATION	0	9,632	2,356	11,988	194.01
194.02 07952	MARKETING	0	930	227	1,157	194.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	48,552	1,689,123	413,083	2,150,758	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144034

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

Worksheet B  
Part II  
Date/Time Prepared:  
10/29/2012 11:53 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	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	500,579				5.00
7.00	00700	OPERATION OF PLANT	35,319	181,679			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,771	3,640	39,543		8.00
9.00	00900	HOUSEKEEPING	14,653	1,738	0	30,780	9.00
10.00	01000	DIETARY	25,336	14,451	0	2,523	161,922
13.00	01300	NURSING ADMINISTRATION	37,348	2,108	0	368	0
16.00	01600	MEDICAL RECORDS & LIBRARY	12,543	2,023	0	353	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	299,776	144,075	39,099	25,154	160,105
46.00	04600	OTHER LONG TERM CARE	3,300	797	444	139	1,817
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	2,329	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	22,290	1,567	0	274	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	19,936	9,692	0	1,692	0
91.00	09100	EMERGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		<b>SUBTOTALS (SUM OF LINES 1-117)</b>	<b>478,601</b>	<b>180,091</b>	<b>39,543</b>	<b>30,503</b>	<b>161,922</b>
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	EDUCATION	10,971	1,448	0	253	0
194.02	07952	MARKETING	11,007	140	0	24	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		<b>TOTAL (sum lines 118-201)</b>	<b>500,579</b>	<b>181,679</b>	<b>39,543</b>	<b>30,780</b>	<b>161,922</b>

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144034

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

Worksheet B  
Part II  
Date/Time Prepared:  
10/29/2012 11:53 am

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	16.00	17.00	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
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
13.00	01300	NURSING ADMINISTRATION	57,270				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,667			16.00
17.00	01700	SOCIAL SERVICES	0	0	0		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	56,627	31,312	0	1,948,709	30.00
46.00	04600	OTHER LONG TERM CARE	643	355	0	14,089	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	2,329	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	37,101	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	111,542	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	57,270	31,667	0	2,113,770	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	EDUCATION	0	0	0	24,660	194.01
194.02	07952	MARKETING	0	0	0	12,328	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	57,270	31,667	0	2,150,758	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144034

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

worksheet B  
Part II  
Date/Time Prepared:  
10/29/2012 11:53 am

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
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
13.00	01300 NURSING ADMINISTRATION		13.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS	1,948,709	30.00
46.00	04600 OTHER LONG TERM CARE	14,089	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000 LABORATORY	2,329	60.00
67.00	06700 OCCUPATIONAL THERAPY	0	67.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	37,101	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000 CLINIC	111,542	90.00
91.00	09100 EMERGENCY	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,113,770	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	07951 EDUCATION	24,660	194.01
194.02	07952 MARKETING	12,328	194.02
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	2,150,758	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144034

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

Worksheet B-1  
Date/Time Prepared:  
10/29/2012 11:53 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	CAP REL COSTS-BLDG & FIXT	96,277			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		96,277		2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	12,558,572	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,702	20,702	1,817,596	5.00
7.00	00700	OPERATION OF PLANT	6,703	6,703	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,380	1,380	0	8.00
9.00	00900	HOUSEKEEPING	659	659	0	9.00
10.00	01000	DIETARY	5,478	5,478	313,620	10.00
13.00	01300	NURSING ADMINISTRATION	799	799	1,030,881	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	767	767	229,726	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	54,617	54,617	7,515,976	30.00
46.00	04600	OTHER LONG TERM CARE	302	302	84,346	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	594	594	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	3,674	3,674	1,003,051	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		SUBTOTALS (SUM OF LINES 1-117)	95,675	95,675	11,995,196	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
194.01	07951	EDUCATION	549	549	297,320	194.01
194.02	07952	MARKETING	53	53	266,056	194.02
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)	1,689,123	413,083	2,907,643	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	17.544408	4.290568	0.231527	203.00
204.00		Cost to be allocated (per wkst. B, Part II)			0	204.00
205.00		Unit cost multiplier (wkst. B, Part II)			0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144034

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

Worksheet B-1

Date/Time Prepared:  
10/29/2012 11:53 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (PATIENT DAYS)	
		7.00	8.00	9.00	10.00	13.00	
<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
7.00	00700	OPERATION OF PLANT	68,872				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,380	40,905			8.00
9.00	00900	HOUSEKEEPING	659	0	66,833		9.00
10.00	01000	DIETARY	5,478	0	5,478	122,715	10.00
13.00	01300	NURSING ADMINISTRATION	799	0	799	0	40,905
16.00	01600	MEDICAL RECORDS & LIBRARY	767	0	767	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	54,617	40,446	54,617	121,338	40,446
46.00	04600	OTHER LONG TERM CARE	302	459	302	1,377	459
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	594	0	594	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	3,674	0	3,674	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	68,270	40,905	66,231	122,715	40,905
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	EDUCATION	549	0	549	0	0
194.02	07952	MARKETING	53	0	53	0	0
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)	1,549,971	284,326	657,874	1,289,082	1,664,852
203.00		Unit cost multiplier (wkst. B, Part I)	22.505096	6.950886	9.843550	10.504682	40.700452
204.00		Cost to be allocated (per wkst. B, Part II)	181,679	39,543	30,780	161,922	57,270
205.00		Unit cost multiplier (wkst. B, Part II)	2.637923	0.966703	0.460551	1.319496	1.400073

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144034

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

Worksheet B-1  
Date/Time Prepared:  
10/29/2012 11:53 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	
		16.00	17.00	
<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
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
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	40,905	16.00
17.00	01700	SOCIAL SERVICE	0 40,905	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	40,446	30.00
46.00	04600	OTHER LONG TERM CARE	459 459	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0 0	54.00
60.00	06000	LABORATORY	0 0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0 0	67.00
69.00	06900	ELECTROCARDIOLOGY	0 0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0 0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0 0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0 0	90.00
91.00	09100	EMERGENCY	0 0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00		SUBTOTALS (SUM OF LINES 1-117)	40,905 40,905	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0 0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0 0	194.00
194.01	07951	EDUCATION	0 0	194.01
194.02	07952	MARKETING	0 0	194.02
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)	575,237 0	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	14.062755 0.000000	203.00
204.00		Cost to be allocated (per wkst. B, Part II)	31,667 0	204.00
205.00		Unit cost multiplier (wkst. B, Part II)	0.774160 0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

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

Worksheet C  
Part I  
Date/Time Prepared:  
10/29/2012 11:53 am

		Title XIX		Hospital		Cost	
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	18,692,921		18,692,921	0	0 30.00
46.00	04600	OTHER LONG TERM CARE	197,391		197,391	0	0 46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		0	0	0 54.00
60.00	06000	LABORATORY	102,221		102,221	0	0 60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0 70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	997,416		997,416	0	0 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	993,714		993,714	0	0 90.00
91.00	09100	EMERGENCY	0		0	0	0 91.00
200.00		Subtotal (see instructions)	20,983,663	0	20,983,663	0	0 200.00
201.00		Less Observation Beds	0		0	0	0 201.00
202.00		Total (see instructions)	20,983,663	0	20,983,663	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:144034

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

Worksheet C  
Part I  
Date/Time Prepared:  
10/29/2012 11:53 am

Cost Center Description		Title XIX			Hospital	Cost		
		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00	9.00	10.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	56,638,390		56,638,390			30.00
46.00	04600	OTHER LONG TERM CARE	229,934		229,934			46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	06000	LABORATORY	142,651	0	142,651	0.716581	0.000000	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,594,676	0	1,594,676	0.625466	0.000000	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	4,475,325	4,475,325	0.222043	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
200.00		Subtotal (see instructions)	58,605,651	4,475,325	63,080,976			200.00
201.00		Less observation Beds						201.00
202.00		Total (see instructions)	58,605,651	4,475,325	63,080,976			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

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

Worksheet C  
Part I  
Date/Time Prepared:  
10/29/2012 11:53 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
46.00	04600	OTHER LONG TERM CARE			46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
200.00		Subtotal (see instructions)			200.00
201.00		Less observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 144034

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

Worksheet D  
Part I  
Date/Time Prepared:  
10/29/2012 11:53 am

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	1,948,709	0	1,948,709	40,446	48.18	30.00
200.00		Total (lines 30-199)	1,948,709		1,948,709	40,446		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN:144034	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part I Date/Time Prepared: 10/29/2012 11:53 am
--	--	---------------------	---	---

Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XIX	Hospital	Cost
		6.00	7.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	26,327	1,268,435		30.00
200.00		Total (lines 30-199)	26,327	1,268,435		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 144034

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

Worksheet D  
Part II  
Date/Time Prepared:  
10/29/2012 11:53 am

Cost Center Description		Title XIX			Hospital	Cost		
		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>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0	0	54.00
60.00	06000	LABORATORY	2,329	142,651	0.016327	86,617	1,414	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,101	1,594,676	0.023266	934,725	21,747	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	111,542	4,475,325	0.024924	0	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
200.00		Total (lines 50-199)	150,972	6,212,652		1,021,342	23,161	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 144034		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 10/29/2012 11:53 am		
Cost Center Description		Title XIX			Hospital		Cost	
		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
200.00		Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 144034		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 10/29/2012 11:53 am		
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School Cost	
			6.00	7.00	8.00	9.00	11.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	40,446	0.00	26,327	0	0	30.00
200.00		Total (lines 30-199)	40,446		26,327	0		0,200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 144034	Period: From 07/01/2011 To 06/30/2012	worksheet D Part III Date/Time Prepared: 10/29/2012 11:53 am
---	----------------------	---	---

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
200.00   Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 144034	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 10/29/2012 11:53 am
--	----------------------	---	--

Cost Center Description	Title XIX				Hospital	Total Cost (sum of col 1 through col. 4)		
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost			
	1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<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
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: 144034

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

Worksheet D  
Part IV  
Date/Time Prepared:  
10/29/2012 11:53 am

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>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	142,651	0.000000	0.000000	86,617	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,594,676	0.000000	0.000000	934,725	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	4,475,325	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00
200.00		Total (lines 50-199)	0	6,212,652			1,021,342	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

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

worksheet D  
Part IV  
Date/Time Prepared:  
10/29/2012 11:53 am

Cost Center Description			Title XIX			Hospital		
			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>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<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
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: 144034

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

Worksheet D  
Part IV  
Date/Time Prepared:  
10/29/2012 11:53 am

Cost Center Description			PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	Cost
			23.00	24.00			
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0			54.00
60.00	06000	LABORATORY	0	0			60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0			67.00
69.00	06900	ELECTROCARDIOLOGY	0	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0			70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0			90.00
91.00	09100	EMERGENCY	0	0			91.00
200.00		Total (lines 50-199)	0	0			200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN:144034

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

Worksheet D-1

Date/Time Prepared:  
10/29/2012 11:53 am

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)	40,446	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	40,446	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)	40,446	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)	26,327	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)	18,692,921	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	18,692,921	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>			
28.00	General inpatient routine service charges (excluding swing-bed charges)	56,638,260	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	56,638,260	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.330041	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)	1,400.34	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)	18,692,921	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)	462.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	12,167,550	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)	12,167,550	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144034

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

worksheet D-1

Date/Time Prepared:  
10/29/2012 11:53 am

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 NURSERY (title V & XIX only)					42.00
<b>Intensive Care Type Inpatient Hospital Units</b>					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
<b>Cost Center Description</b>					
					1.00
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					646,707
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					12,814,257
<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
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					0
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
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
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (See instructions)					0
<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
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
<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)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144034

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

Worksheet D-1

Date/Time Prepared:  
10/29/2012 11:53 am

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 144034	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 10/29/2012 11:53 am
--	----------------------	---	---

Cost Center Description	Title XIX		Hospital		Cost
	Ratio of Cost To 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		34,583,900	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	54.00
60.00	06000	LABORATORY	0.716581	86,617	60.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.625466	934,725	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.222043	0	90.00
91.00	09100	EMERGENCY	0.000000	0	91.00
200.00		Total (sum of lines 50-94 and 96-98)		1,021,342	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		1,021,342	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144034	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part VII Date/Time Prepared: 10/29/2012 11:53 am
		Title XIX	Hospital	Cost
				1.00
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services		12,814,257	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		12,814,257	4.00
5.00	Inpatient primary payer payments		1,078,018	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		11,736,239	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges		34,583,900	8.00
9.00	Ancillary service charges		1,021,342	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		35,605,242	12.00
<b>CUSTOMARY CHARGES</b>				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		35,605,242	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		22,790,985	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		12,814,257	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.		12,814,257	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		11,736,239	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		11,736,239	36.00
37.00	ELIMINATE SETTLEMENT		9,217,608	37.00
38.00	Subtotal (line 36 ± line 37)		20,953,847	38.00
39.00	Direct graduate medical education payments (from wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		20,953,847	40.00
41.00	Interim payments		20,837,481	41.00
42.00	Balance due provider/program (line 40 minus 41)		116,366	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	43.00

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

Provider CCN: 144034

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

Worksheet G

Date/Time Prepared:  
10/29/2012 11:53 am

		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	-163,741	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	19,794,266	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,930,538	0	0	0	6.00
7.00	Inventory	101,860	0	0	0	7.00
8.00	Prepaid expenses	115,298	0	0	0	8.00
9.00	Other current assets	171	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	<b>Total current assets (sum of lines 1-10)</b>	<b>17,917,316</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>11.00</b>
<b>FIXED ASSETS</b>						
12.00	Land	2,240,512	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	19,349,308	0	0	0	15.00
16.00	Accumulated depreciation	-1,304,392	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	2,418,967	0	0	0	23.00
24.00	Accumulated depreciation	-467,302	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	<b>Total fixed assets (sum of lines 12-29)</b>	<b>22,237,093</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>30.00</b>
<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	61,412,777	0	0	0	34.00
35.00	<b>Total other assets (sum of lines 31-34)</b>	<b>61,412,777</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>35.00</b>
36.00	<b>Total assets (sum of lines 11, 30, and 35)</b>	<b>101,567,186</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>36.00</b>
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	522,910	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,222,222	0	0	0	38.00
39.00	Payroll taxes payable	923,264	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	<b>Total current liabilities (sum of lines 37 thru 44)</b>	<b>2,668,396</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>45.00</b>
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	10,677,194	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	77,392,201	0	0	0	49.00
50.00	<b>Total long term liabilities (sum of lines 46 thru 49)</b>	<b>88,069,395</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>50.00</b>
51.00	<b>Total liabilities (sum of lines 45 and 50)</b>	<b>90,737,791</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>51.00</b>
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	10,829,395	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	<b>Total fund balances (sum of lines 52 thru 58)</b>	<b>10,829,395</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>59.00</b>
60.00	<b>Total liabilities and fund balances (sum of lines 51 and 59)</b>	<b>101,567,186</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>60.00</b>

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 144034

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

worksheet G-1

Date/Time Prepared:  
10/29/2012 11:53 am

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
	1.00		3,022,592		
2.00		7,806,801			2.00
3.00		10,829,393		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
11.00		10,829,393		0	11.00
12.00	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		0		0	18.00
19.00		10,829,393		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 144034

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

Worksheet G-1

Date/Time Prepared:  
10/29/2012 11:53 am

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00			0		0	1.00
2.00						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
11.00		0			0	11.00
12.00	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		0			0	18.00
19.00		0			0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 144034

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

Worksheet G-2 Parts

Date/Time Prepared:  
10/29/2012 11:53 am

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	56,638,260		56,638,260	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	229,937		229,937	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	56,868,197		56,868,197	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	56,868,197		56,868,197	17.00
18.00	Ancillary services	1,737,457		1,737,457	18.00
19.00	Outpatient services	0	4,475,325	4,475,325	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN FEES	597,947	0	597,947	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	59,203,601	4,475,325	63,678,926	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per wkst. A, column 3, line 200)		28,853,189		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		28,853,189		43.00

## STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 144034

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

worksheet G-3

Date/Time Prepared:  
10/29/2012 11:53 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	63,678,926	1.00
2.00	Less contractual allowances and discounts on patients' accounts	27,048,468	2.00
3.00	Net patient revenues (line 1 minus line 2)	36,630,458	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,853,189	4.00
5.00	Net income from service to patients (line 3 minus line 4)	7,777,269	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	4,485	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	14,491	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	2,104	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	8,452	24.00
25.00	Total other income (sum of lines 6-24)	29,532	25.00
26.00	Total (line 5 plus line 25)	7,806,801	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	7,806,801	29.00