

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
Provider CCN: 140100
Period: From 07/01/2012 To 06/30/2013
Worksheet 5
Parts I-III
Date/Time Prepared: 11/16/2013 12:00 pm

PART I - COST REPORT STATUS

Provider use only: 1. [ X ] Electronically filed cost report Date: 11/16/2013 Time: 12:00 pm
2. [ ] Manually submitted cost report
3. [ 0 ] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [ F ] Medicare Utilization. Enter "F" for full or "L" for low.
Contractor use only: 5. [ 1 ] Cost Report Status 6. Date Received:
(1) As Submitted 7. Contractor No. 10. NPR Date:
(2) Settled without Audit 8. [ N ] Initial Report for this Provider CCN 11. Contractor's Vendor Code: 4
(3) Settled with Audit 9. [ N ] Final Report for this Provider CCN 12. [ 0 ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.
(4) Reopened
(5) Amended

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MIDWESTERN REGIONAL MEDICAL CENTER ( 140100 ) for the cost reporting period beginning 07/01/2012 and ending 06/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) [Signature]
Officer or Administrator of Provider(s)
Title CFO
Date November 27, 2013

Table with columns: Cost Center Description, Title v, Title XVIII (Part A, Part B), HIT, Title XIX. Rows include Hospital, Subprovider - IPF, Subprovider - IRF, Swing bed - SNF, Swing bed - NF, and Total.

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: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet S-2  
Part I  
Date/Time Prepared:  
11/16/2013 12:00 pm

	1.00	2.00	3.00	4.00	
	<b>Hospital and Hospital Health Care Complex Address:</b>				
1.00	Street: 2501 EMMAUS AVENUE		PO Box:		1.00
2.00	City: ZION		State: IL	Zip Code: 60099	County: LAKE
					2.00

	<b>Component Name</b>	<b>CCN Number</b>	<b>CBSA Number</b>	<b>Provider Type</b>	<b>Date Certified</b>	<b>Payment System (P, T, O, or N)</b>		
						V	XVIII	XIX
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00

	<b>Hospital and Hospital-Based Component Identification:</b>									
3.00	Hospital	MIDWESTERN REGIONAL MEDICAL CENTER	140100	29404	1	07/01/1967	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		<b>From:</b>	<b>To:</b>	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2012	06/30/2013	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	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0	N	23.00

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

		<b>Urban/Rural S</b>	<b>Date of Geogr</b>	
		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	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140100	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/16/2013 12:00 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.		0			37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.					39.00
		V 1.00	XVIII 2.00	XIX 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 additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
<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 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00		0.00	61.00
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)		0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)		0.00			62.01
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 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. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
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		0.00	0.00	0.000000	66.00
Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.		0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
<b>Inpatient Psychiatric Facility PPS</b>					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00
			1.00		
<b>Long Term Care Hospital PPS</b>					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		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.				86.00
		V	XIX		
		1.00	2.00		
<b>Title V and XIX Services</b>					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		97.00
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109.00
				1.00	2.00
				3.00	4.00
<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
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2		118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	3,925,030	0		118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
<b>Transplant Center Information</b>					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
<b>All Providers</b>					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	14H130	140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: CANCER TREATMENT CENTERS OF AMERICA	Contractor's Name: NGS		Contractor's Number: 00131	141.00
142.00	Street: 1336 BASSWOOD ROAD	PO Box:	6775 W WA		142.00
143.00	City: SCHAUMBURG, IL 60173	State:	IL	Zip Code: 53214	143.00
				1.00	
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	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140100			Period: From 07/01/2012 To 06/30/2013		Worksheet S-2 Part I Date/Time Prepared: 11/16/2013 12:00 pm																																
								1.00																															
<b>Multicampus</b>																																							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00																														
<table border="1"> <thead> <tr> <th>Name</th> <th>County</th> <th>State</th> <th>Zip Code</th> <th>CBSA</th> <th>FTE/Campus</th> </tr> <tr> <th>0</th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> </tr> </thead> <tbody> <tr> <td>166.00</td> <td colspan="5">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</td> <td>0.00</td> <td>166.00</td> </tr> <tr> <td colspan="8"></td> <td>1.00</td> <td></td> </tr> </tbody> </table>										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	
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																															
<b>Health Information Technology (HIT) Incentive in the American Recovery and Reinvestment Act</b>																																							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.							N	167.00																														
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00																														
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00																														

		Y/N	Date	
		1.00	2.00	
<b>General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.</b>				
<b>COMPLETED BY ALL HOSPITALS</b>				
<b>Provider Organization and Operation</b>				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "v" for voluntary or "i" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
<b>Financial Data and Reports</b>				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions)	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
<b>Approved Educational Activities</b>				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N		11.00
			Y/N	
			1.00	
<b>Bad Debts</b>				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
<b>Bed Complement</b>				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		Y	15.00
		Part A		Part B
Description		Y/N	Date	Y/N
0		1.00	2.00	3.00
<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	08/19/2013	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for other? Describe the other adjustments:	N		N

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N	2.00	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			Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	COREY		RUTLEDGE	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	612-376-4500		COREY.RUTLEDGE@CLACONNECT.CO	43.00

		Part 8 Date 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)	08/19/2013	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PRINCIPAL	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	53	19,345	0.00	0	1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		53	19,345	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	12	4,380	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		73	26,645	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
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)		73				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	1,488	19	10,514			1.00
2.00 HMO	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	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)	1,488	19	10,514			7.00
8.00 INTENSIVE CARE UNIT	127	3	1,615			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT	145	4	1,838			11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	1,760	26	13,967	0.00	1,109.83	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	1,109.83	27.00
28.00 Observation Bed Days		4	1,009			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

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)			0	194	8	1,857	1.00
2.00 HMO				0			2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	194	8	1,857		14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						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 WAGE INDEX INFORMATION

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet S-3  
Part II  
Date/Time Prepared:  
11/16/2013 12:00 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	68,365,774	0	68,365,774	2,308,454.30	29.62 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician-Part B		0	0	0	0.00	0.00 5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		6,101,185	536,373	6,637,558	273,565.33	24.26 10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor (see instructions)		1,475,380	0	1,475,380	23,450.00	62.92 11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		586,942	0	586,942	6,841.00	85.80 13.00
14.00	Home office salaries & wage-related costs		30,019,764	0	30,019,764	274,329.00	109.43 14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) wkst S-3, Part IV line 24		20,487,568	0	20,487,568		17.00
18.00	Wage-related costs (other)wkst S-3, Part IV line 25		0	0	0		18.00
19.00	Excluded areas		2,863,756	0	2,863,756		19.00
20.00	Non-physician anesthetist Part A		0	0	0		20.00
21.00	Non-physician anesthetist Part B		0	0	0		21.00
22.00	Physician Part A - Administrative		0	0	0		22.00
22.01	Physician Part A - Teaching		0	0	0		22.01
23.00	Physician Part B		0	0	0		23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0		24.00
25.00	Interns & residents (in an approved program)		0	0	0		25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits	4.00	7,422,309	-6,221,189	1,201,120	22,779.20	52.73 26.00
27.00	Administrative & General	5.00	5,461,106	1,405,614	6,866,720	218,307.77	31.45 27.00
28.00	Administrative & General under contract (see inst.)		464,962	0	464,962	1,568.00	296.53 28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00 29.00
30.00	Operation of Plant	7.00	1,480,350	127,123	1,607,473	60,750.58	26.46 30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00 31.00
32.00	Housekeeping	9.00	1,308,895	112,400	1,421,295	95,393.90	14.90 32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00 33.00
34.00	Dietary	10.00	1,794,398	-1,520,352	274,046	17,078.20	16.05 34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00 35.00
36.00	Cafeteria	11.00	0	1,674,443	1,674,443	104,348.79	16.05 36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00 37.00
38.00	Nursing Administration	13.00	1,029,705	88,425	1,118,130	37,432.76	29.87 38.00
39.00	Central Services and Supply	14.00	371,393	31,893	403,286	20,908.40	19.29 39.00
40.00	Pharmacy	15.00	2,148,111	184,466	2,332,577	65,022.36	35.87 40.00
41.00	Medical Records & Medical Records Library	16.00	2,204,527	189,311	2,393,838	96,099.54	24.91 41.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet S-3  
Part II  
Date/Time Prepared:  
11/16/2013 12:00 pm

		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Social Service	17.00	901,799	116,104	1,017,903	39,624.70	25.69	42.00
43.00	Other General Service	18.00	6,100,097	523,837	6,623,934	198,002.19	33.45	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet S-3  
Part III  
Date/Time Prepared:  
11/16/2013 12:00 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	68,830,736	0	68,830,736	2,310,022.30	29.80	1.00
2.00	Excluded area salaries (see instructions)	6,101,185	536,373	6,637,558	273,565.33	24.26	2.00
3.00	Subtotal salaries (line 1 minus line 2)	62,729,551	-536,373	62,193,178	2,036,456.97	30.54	3.00
4.00	Subtotal other wages & related costs (see inst.)	32,082,086	0	32,082,086	304,620.00	105.32	4.00
5.00	Subtotal wage-related costs (see inst.)	20,487,568	0	20,487,568	0.00	32.94	5.00
6.00	Total (sum of lines 3 thru 5)	115,299,205	-536,373	114,762,832	2,341,076.97	49.02	6.00
7.00	Total overhead cost (see instructions)	30,687,652	-3,287,925	27,399,727	977,316.39	28.04	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013Worksheet s-3  
Part IV  
Date/Time Prepared:  
11/16/2013 12:00 pm

		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401k Employer Contributions	1,368,695	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401k/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	9,236,274	8.00
9.00	Prescription Drug Plan	2,418,406	9.00
10.00	Dental, Hearing and Vision Plan	978,391	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	104,535	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	487,420	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	763,324	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	7,367	14.00
15.00	'Workers' Compensation Insurance	357,926	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	3,890,263	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	505,040	20.00
<b>OTHER</b>			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	369,927	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	20,487,568	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet S-3  
Part V  
Date/Time Prepared:  
11/16/2013 12:00 PM

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

		1.00			
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.231730	1.00		
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid	210,472	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	2,630,895	6.00		
7.00	Medicaid cost (line 1 times line 6)	609,657	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)	399,185	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)	399,185	19.00		
		Uninsured patients	Insured patients		
		1.00	2.00		
		Total (col. 1 + col. 2)			
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,341,627	18,555,129	19,896,756	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	310,895	4,299,780	4,610,675	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	310,895	4,299,780	4,610,675	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			21,258,750	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			329,167	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)			20,929,583	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)			4,850,012	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			9,460,687	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			9,859,872	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet A

Date/Time Prepared:  
11/16/2013 12:00 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT		10,646,166	10,646,166	1,987,244	12,633,410	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		10,628,524	10,628,524	0	10,628,524	2.00
4.00	00400	EMPLOYEE BENEFITS	7,422,309	17,918,193	25,340,502	-5,392,998	19,947,504	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,461,106	365,676,719	371,137,825	168,011	371,305,836	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,480,350	4,347,532	5,827,882	127,123	5,955,005	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	210,153	210,153	0	210,153	8.00
9.00	00900	HOUSEKEEPING	1,308,895	733,769	2,042,664	112,400	2,155,064	9.00
10.00	01000	DIETARY	1,794,398	3,285,347	5,079,745	-4,343,629	736,116	10.00
11.00	01100	CAFETERIA	0	0	0	4,497,720	4,497,720	11.00
13.00	01300	NURSING ADMINISTRATION	1,029,705	668,343	1,698,048	88,425	1,786,473	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	371,393	374,993	746,386	31,893	778,279	14.00
15.00	01500	PHARMACY	2,148,111	609,901	2,758,012	184,466	2,942,478	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,204,527	528,412	2,732,939	189,311	2,922,250	16.00
17.00	01700	SOCIAL SERVICE	901,799	395,669	1,297,468	231,804	1,529,272	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	6,100,097	1,496,248	7,596,345	523,837	8,120,182	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	6,912,751	2,117,470	9,030,221	593,623	9,623,844	30.00
31.00	03100	INTENSIVE CARE UNIT	1,619,568	372,343	1,991,911	139,078	2,130,989	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,259,029	216,931	1,475,960	108,117	1,584,077	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	3,503,689	1,719,325	5,223,014	300,874	5,523,888	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,783,284	1,589,622	4,372,906	239,011	4,611,917	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,873,733	3,224,667	5,098,400	160,904	5,259,304	55.00
56.00	05600	RADIOISOTOPE	378,740	109,634	488,374	32,524	520,898	56.00
57.00	05700	CT SCAN	477,141	226,094	703,235	40,974	744,209	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	305,325	157,629	462,954	26,219	489,173	58.00
60.00	06000	LABORATORY	2,717,102	3,436,107	6,153,209	233,327	6,386,536	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,960,589	1,960,589	0	1,960,589	63.00
64.00	06400	INTRAVENOUS THERAPY	1,888,267	421,021	2,309,288	162,152	2,471,440	64.00
65.00	06500	RESPIRATORY THERAPY	724,112	122,107	846,219	62,182	908,401	65.00
66.00	06600	PHYSICAL THERAPY	778,942	415,493	1,194,435	66,891	1,261,326	66.00
69.00	06900	ELECTROCARDIOLOGY	321,345	93,598	414,943	27,595	442,538	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,234,048	14,234,048	0	14,234,048	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	77,548,488	77,548,488	0	77,548,488	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	778,218	128,602	906,820	66,828	973,648	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	4,610,318	804,190	5,414,508	395,905	5,810,413	90.00
91.00	09100	EMERGENCY	1,110,335	1,393,102	2,503,437	95,348	2,598,785	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE		2,103,995	2,103,995	-1,926,314	177,681	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	62,264,589	529,915,024	592,179,613	-769,155	591,410,458	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	51,466	139,237	190,703	4,420	195,123	190.00
191.00	19100	RESEARCH	300,301	45,043	345,344	25,788	371,132	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	5,749,418	32,744,540	38,493,958	738,947	39,232,905	194.00
200.00		TOTAL (SUM OF LINES 118-199)	68,365,774	562,843,844	631,209,618	0	631,209,618	200.00

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-4,566,982	8,066,428	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	663,684	11,292,208	2.00
4.00	00400 EMPLOYEE BENEFITS	-442,819	19,504,685	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-309,868,631	61,437,205	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700 OPERATION OF PLANT	-46	5,954,959	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	210,153	8.00
9.00	00900 HOUSEKEEPING	-8,437	2,146,627	9.00
10.00	01000 DIETARY	-1,634	734,482	10.00
11.00	01100 CAFETERIA	-3,724,769	772,951	11.00
13.00	01300 NURSING ADMINISTRATION	14,475	1,800,948	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	778,279	14.00
15.00	01500 PHARMACY	-207	2,942,271	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-9,291	2,912,959	16.00
17.00	01700 SOCIAL SERVICE	-183,536	1,345,736	17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	-56,209	8,063,973	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS	-1,660	9,622,184	30.00
31.00	03100 INTENSIVE CARE UNIT	7	2,130,996	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	1,584,077	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	28	5,523,916	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	165	4,612,082	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	-3,267	5,256,037	55.00
56.00	05600 RADIOISOTOPE	0	520,898	56.00
57.00	05700 CT SCAN	0	744,209	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	489,173	58.00
60.00	06000 LABORATORY	675	6,387,211	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	73	1,960,662	63.00
64.00	06400 INTRAVENOUS THERAPY	122	2,471,562	64.00
65.00	06500 RESPIRATORY THERAPY	-65	908,336	65.00
66.00	06600 PHYSICAL THERAPY	0	1,261,326	66.00
69.00	06900 ELECTROCARDIOLOGY	0	442,538	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,234,048	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	77,548,488	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01	03951 HOSPITAL NUTRITION	19	973,667	76.01
76.02	03952 PAIN MANAGEMENT	0	0	76.02
76.03	03954 INFUSION CENTER	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	-3,259	5,807,154	90.00
91.00	09100 EMERGENCY	-668,557	1,930,228	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE	-177,681	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-319,037,802	272,372,656	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	195,123	190.00
191.00	19100 RESEARCH	0	371,132	191.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	2	39,232,907	194.00
200.00	TOTAL (SUM OF LINES 118-199)	-319,037,800	312,171,818	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - RECLASS CAFETERIA</b>					
1.00	CAFETERIA	11.00	1,674,443	2,823,277	1.00
	TOTALS		1,674,443	2,823,277	
<b>B - EMPLOYEE BONUS</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	1,404,368	0	1.00
2.00	OPERATION OF PLANT	7.00	127,123	0	2.00
3.00	HOUSEKEEPING	9.00	112,400	0	3.00
4.00	DIETARY	10.00	154,091	0	4.00
5.00	NURSING ADMINISTRATION	13.00	88,425	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	31,893	0	6.00
7.00	PHARMACY	15.00	184,466	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	189,311	0	8.00
9.00	SOCIAL SERVICE	17.00	77,441	0	9.00
10.00	OTHER GENERAL SERVICE (SPECIFY)	18.00	523,837	0	10.00
11.00	ADULTS & PEDIATRICS	30.00	593,623	0	11.00
12.00	INTENSIVE CARE UNIT	31.00	139,078	0	12.00
13.00	SURGICAL INTENSIVE CARE UNIT	34.00	108,117	0	13.00
14.00	OPERATING ROOM	50.00	300,874	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	239,011	0	15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	160,904	0	16.00
17.00	RADIOISOTOPE	56.00	32,524	0	17.00
18.00	CT SCAN	57.00	40,974	0	18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	26,219	0	19.00
20.00	LABORATORY	60.00	233,327	0	20.00
21.00	INTRAVENOUS THERAPY	64.00	162,152	0	21.00
22.00	RESPIRATORY THERAPY	65.00	62,182	0	22.00
23.00	PHYSICAL THERAPY	66.00	66,891	0	23.00
24.00	ELECTROCARDIOLOGY	69.00	27,595	0	24.00
25.00	HOSPITAL NUTRITION	76.01	66,828	0	25.00
26.00	CLINIC	90.00	395,905	0	26.00
27.00	EMERGENCY	91.00	95,348	0	27.00
28.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	4,420	0	28.00
29.00	RESEARCH	191.00	25,788	0	29.00
30.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	546,074	0	30.00
	TOTALS		6,221,189	0	
<b>C - PROPERTY TAX</b>					
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	442,382	1.00
	TOTALS		0	442,382	
<b>D - TRAVEL/SCHEDULING</b>					
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	114,279	26,926	1.00
	TOTALS		114,279	26,926	
<b>E - GUEST SERVICES</b>					
1.00	SOCIAL SERVICE	17.00	38,663	115,700	1.00
	TOTALS		38,663	115,700	
<b>F - INTEREST EXPENSE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,926,314	1.00
	TOTALS		0	1,926,314	
<b>G - INSURANCE EXPENSE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	503,312	1.00
2.00	EMPLOYEE BENEFITS	4.00	0	828,191	2.00
	TOTALS		0	1,331,503	
<b>H - TRANSPORTATION</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	115,525	120,826	1.00
	TOTALS		115,525	120,826	
500.00	Grand Total: Increases		8,164,099	6,786,928	500.00

		Decreases				
Cost Center		Line #	Salary	Other	wkst. A-7 Ref.	
6.00		7.00	8.00	9.00	10.00	
<b>A - RECLASS CAFETERIA</b>						
1.00	DIETARY	10.00	1,674,443	2,823,277	0	1.00
	TOTALS		1,674,443	2,823,277		
<b>B - EMPLOYEE BONUS</b>						
1.00	EMPLOYEE BENEFITS	4.00	6,221,189	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
21.00		0.00	0	0	0	21.00
22.00		0.00	0	0	0	22.00
23.00		0.00	0	0	0	23.00
24.00		0.00	0	0	0	24.00
25.00		0.00	0	0	0	25.00
26.00		0.00	0	0	0	26.00
27.00		0.00	0	0	0	27.00
28.00		0.00	0	0	0	28.00
29.00		0.00	0	0	0	29.00
30.00		0.00	0	0	0	30.00
	TOTALS		6,221,189	0		
<b>C - PROPERTY TAX</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	442,382	13	1.00
	TOTALS		0	442,382		
<b>D - TRAVEL/SCHEDULING</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	114,279	26,926	0	1.00
	TOTALS		114,279	26,926		
<b>E - GUEST SERVICES</b>						
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	38,663	115,700	0	1.00
	TOTALS		38,663	115,700		
<b>F - INTEREST EXPENSE</b>						
1.00	INTEREST EXPENSE	113.00	0	1,926,314	11	1.00
	TOTALS		0	1,926,314		
<b>G - INSURANCE EXPENSE</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,331,503	12	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	1,331,503		
<b>H - TRANSPORTATION</b>						
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	115,525	120,826	0	1.00
	TOTALS		115,525	120,826		
500.00	Grand Total: Decreases		8,164,099	6,786,928		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet A-7  
Part I  
Date/Time Prepared:  
11/16/2013 12:00 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	1,219,708	0	0	-350,280	2.00
3.00	Buildings and Fixtures	23,798,205	15,866,188	0	0	3.00
4.00	Building Improvements	36,471,198	1,136,994	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	7,976,945	161,840	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	69,466,056	17,165,022	0	-350,280	8.00
9.00	Reconciling Items	1,759,132	15,866,188	0	0	9.00
10.00	Total (line 8 minus line 9)	67,706,924	1,298,834	0	-350,280	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	0	0			1.00
2.00	Land Improvements	1,569,988	0			2.00
3.00	Buildings and Fixtures	39,664,393	0			3.00
4.00	Building Improvements	37,608,192	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	8,138,785	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	86,981,358	0			8.00
9.00	Reconciling Items	17,625,320	0			9.00
10.00	Total (line 8 minus line 9)	69,356,038	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet A-7  
Part II  
Date/Time Prepared:  
11/16/2013 12:00 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	CAP REL COSTS-BLDG & FIXT	3,408,740	0	0	0	2,630,536	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,977,556	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	11,386,296	0	0	0	2,630,536	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	CAP REL COSTS-BLDG & FIXT	4,606,890	10,646,166				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,650,968	10,628,524				2.00
3.00	Total (sum of lines 1-2)	7,257,858	21,274,690				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet A-7  
Part III  
Date/Time Prepared:  
11/16/2013 12:00 PM

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
<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
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,033,517	-4,308,149	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	8,641,240	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,674,757	-4,308,149	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1,042,704	503,312	2,188,154	4,606,890	8,066,428	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,650,968	11,292,208	2.00
3.00	Total (sum of lines 1-2)	1,042,704	503,312	2,188,154	7,257,858	19,358,636	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-706,693	CAP REL COSTS-BLDG & FIXT	1.00		11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)		0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00		0	7.00
8.00 Television and radio service (chapter 21)		0		0.00		0	8.00
9.00 Parking lot (chapter 21)		0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-668,557				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-310,305,087				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-1,273,407	CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employee and others		0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-3,000	RADIOLOGY-THERAPEUTIC	55.00		0	16.00
17.00 Sale of drugs to other than patients		0		0.00		0	17.00
18.00 Sale of medical records and abstracts	B	14	ADMINISTRATIVE & GENERAL	5.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00		0	19.00
20.00 Vending machines	B	-885	CAFETERIA	11.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	-28,060	CAP REL COSTS-BLDG & FIXT	1.00		9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-976,069	CAP REL COSTS-MVBLE EQUIP	2.00		9	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant		0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00			30.00
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		0	32.00
33.00 OTHER REVENUE	B	-75	EMPLOYEE BENEFITS	4.00		0	33.00
33.01 OTHER REVENUE	B	-1,809,053	ADMINISTRATIVE & GENERAL	5.00		0	33.01
33.02 OTHER REVENUE	B	-243	PHARMACY	15.00		0	33.02
33.03 OTHER REVENUE	B	-90,632	SOCIAL SERVICE	17.00		0	33.03

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted		Line #	Wkst. A-7	Ref.
			Cost Center				
	1.00	2.00	3.00		4.00	5.00	
33.04 OTHER REVENUE	B	-9,402	MEDICAL RECORDS & LIBRARY		16.00		0 33.04
33.05 OTHER REVENUE	B	-612	OTHER GENERAL SERVICE (SPECIFY)		18.00		0 33.05
34.00 NON-ALLOWABLE EXPENSE	A	-92,904	SOCIAL SERVICE		17.00		0 34.00
34.01 NON-ALLOWABLE EXPENSE	A	0			0.00		0 34.01
34.02 NON-ALLOWABLE EXPENSE	A	-1,729	ADULTS & PEDIATRICS		30.00		0 34.02
34.03 NON-ALLOWABLE EXPENSE	A	-128	OPERATING ROOM		50.00		0 34.03
34.04 NON-ALLOWABLE EXPENSE	A	-10	LABORATORY		60.00		0 34.04
34.05 NON-ALLOWABLE EXPENSE	A	-40	RADIOLOGY-DIAGNOSTIC		54.00		0 34.05
34.06 NON-ALLOWABLE EXPENSE	A	0			0.00		0 34.06
34.07 NON-ALLOWABLE EXPENSE	A	-32	MEDICAL RECORDS & LIBRARY		16.00		0 34.07
34.08 NON-ALLOWABLE EXPENSE	A	-59,593	OTHER GENERAL SERVICE (SPECIFY)		18.00		0 34.08
34.09 NON-ALLOWABLE EXPENSE	A	-1,634	DIETARY		10.00		0 34.09
34.10 NON-ALLOWABLE EXPENSE	A	0			0.00		0 34.10
34.11 NON-ALLOWABLE EXPENSE	A	-550,880	ADMINISTRATIVE & GENERAL		5.00		0 34.11
34.12 NON-ALLOWABLE EXPENSE	A	-22,510	EMPLOYEE BENEFITS		4.00		0 34.12
34.13 NON-ALLOWABLE EXPENSE	A	-46	OPERATION OF PLANT		7.00		0 34.13
34.14 NON-ALLOWABLE EXPENSE	A	-8,437	HOUSEKEEPING		9.00		0 34.14
34.15 NON-ALLOWABLE EXPENSE	A	-267	RADIOLOGY-THERAPEUTIC		55.00		0 34.15
34.16 NON-ALLOWABLE EXPENSE	A	-106	RESPIRATORY THERAPY		65.00		0 34.16
34.17 NON-ALLOWABLE EXPENSE	A	0			0.00		0 34.17
34.18 NON-ALLOWABLE EXPENSE	A	-3,259	CLINIC		90.00		0 34.18
35.00 CAFETERIA	A	-2,450,477	CAFETERIA		11.00		0 35.00
36.00 EMR AMORTIZATION	A	0			0.00		0 36.00
37.00 EMR AMORTIZATION	A	69	ADULTS & PEDIATRICS		30.00		0 37.00
37.01 EMR AMORTIZATION	A	7	INTENSIVE CARE UNIT		31.00		0 37.01
37.02 EMR AMORTIZATION	A	156	OPERATING ROOM		50.00		0 37.02
37.03 EMR AMORTIZATION	A	122	INTRAVENOUS THERAPY		64.00		0 37.03
37.04 EMR AMORTIZATION	A	685	LABORATORY		60.00		0 37.04
37.05 EMR AMORTIZATION	A	73	BLOOD STORING, PROCESSING & TRANS.		63.00		0 37.05
37.06 EMR AMORTIZATION	A	41	RESPIRATORY THERAPY		65.00		0 37.06
37.07 EMR AMORTIZATION	A	205	RADIOLOGY-DIAGNOSTIC		54.00		0 37.07
37.08 EMR AMORTIZATION	A	36	PHARMACY		15.00		0 37.08
37.09 EMR AMORTIZATION	A	19	HOSPITAL NUTRITION		76.01		0 37.09
37.10 EMR AMORTIZATION	A	2	OTHER NONREIMBURSABLE COST CENTERS		194.00		0 37.10
37.11 EMR AMORTIZATION	A	3,996	OTHER GENERAL SERVICE (SPECIFY)		18.00		0 37.11
37.12 EMR AMORTIZATION	A	5,984	ADMINISTRATIVE & GENERAL		5.00		0 37.12
37.13 EMR AMORTIZATION	A	143	MEDICAL RECORDS & LIBRARY		16.00		0 37.13
37.14 EMR AMORTIZATION	A	14,475	NURSING ADMINISTRATION		13.00		0 37.14
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-319,037,800					50.00

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED</b>					
<b>HOME OFFICE COSTS:</b>					
1.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	97,700,795 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	RIISING TIDE IP REIMBURSEMENT	0	-381,069 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	TRAVEL - AIR CHARTER	112,250	2,760,000 3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	GUARANTEE FEES	0	96,777 4.00
4.01	113.00	INTEREST EXPENSE	INTEREST EXPENSE - OTHER	0	95,625 4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	AMORT EXP - GCF CAP LEASES	4,739,202	4,739,202 4.02
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	AMORT EXP - GCF CAP LEASES - R	0	1,489,821 4.03
4.04	113.00	INTEREST EXPENSE	INTEREST EXPENSE - GCF	0	544,385 4.04
4.05	113.00	INTEREST EXPENSE	INTEREST EXPENSE - CAPITAL LEA	1,926,313	1,463,984 4.05
4.06	1.00	CAP REL COSTS-BLDG & FIXT	RENTAL - BLDG	298,741	4,606,890 4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICES	0	69,866,745 4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	CORPORATE ALLOCATION	0	180,520,532 4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	INSURANCE - COMMERCIAL	393,119	454,534 4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	INSURANCE - STELLAR	888,605	4,756,063 4.10
4.11	1.00	CAP REL COSTS-BLDG & FIXT	INSURANCE - STELLAR	326,395	503,312 4.11
4.12	4.00	EMPLOYEE BENEFITS	INSURANCE - STELLAR	407,957	828,191 4.12
4.13	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	652,837	0 4.13
4.14	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	3,129,574	0 4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	47,046,178	0 4.15
4.16	5.00	ADMINISTRATIVE & GENERAL	BROKERAGE FEES	0	180,471 4.16
5.00	0			59,921,171	370,226,258 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	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
<b>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>				

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

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

6.00	A	MIDWESTERN REG	100.00	NIMP	100.00	6.00
7.00	A	MIDWESTERN REG	100.00	CTCA	100.00	7.00
8.00	A	MIDWESTERN REG	100.00	ICIC	100.00	8.00
9.00	A	MIDWESTERN REG	100.00	INTERNATIONAL A	100.00	9.00
10.00	A	MIDWESTERN REG	100.00	SCL	100.00	10.00
10.01	A	MIDWESTERN REG	100.00	EXPEDITION PROP	100.00	10.01
10.02	A	MIDWESTERN REG	100.00	BUCKLEY RD PR	100.00	10.02
10.03	A	MIDWESTERN REG	100.00	LAND TRUST	100.00	10.03
10.04	A	MIDWESTERN REG	100.00	GCF	100.00	10.04
10.05	A	MIDWESTERN REG	100.00	STELLAR INS	100.00	10.05
10.06	A	MIDWESTERN REG	100.00	ICMC	100.00	10.06
10.07			0.00		0.00	10.07
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

	Net Adjustments (col. 4 minus col. 5)*	wkst. A-7 Ref.	
	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	-97,700,795	0	1.00
2.00	381,069	0	2.00
3.00	-2,647,750	0	3.00
4.00	-96,777	0	4.00
4.01	-95,625	0	4.01
4.02	0	9	4.02
4.03	-1,489,821	9	4.03
4.04	-544,385	0	4.04
4.05	462,329	0	4.05
4.06	-4,308,149	10	4.06
4.07	-69,866,745	0	4.07
4.08	-180,520,532	0	4.08
4.09	-61,415	0	4.09
4.10	-3,867,458	0	4.10
4.11	-176,917	11	4.11
4.12	-420,234	0	4.12
4.13	652,837	9	4.13
4.14	3,129,574	9	4.14
4.15	47,046,178	0	4.15
4.16	-180,471	0	4.16
5.00	-310,305,087		5.00

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

Related Organization(s) and/or Home Office	
Type of Business	
6.00	

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

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

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

6.00	PROPERTY	6.00
7.00	MANAGEMENT	7.00
8.00	CONSULTING	8.00
9.00	CORPORATE JET	9.00
10.00	SECURITIES FINA	10.00
10.01	RENTS BLDG SHAR	10.01
10.02	PROPERTY COMP	10.02
10.03	PROPERTY COMP	10.03
10.04	FINANCIAL	10.04
10.05	INSURANCE	10.05
10.06	CAPITAL MANAGEM	10.06
10.07		10.07
100.00		100.00

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

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

	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,251,358	664,416	586,942	177,200	6,841	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,251,358	664,416	586,942		6,841	200.00
1.00	2.00	8.00	9.00	12.00	13.00	14.00		
1.00	91.00	EMERGENCY	582,801	29,140	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			582,801	29,140	0	0	0	200.00
1.00	2.00	15.00	16.00	17.00	18.00			
1.00	91.00	EMERGENCY	0	582,801	4,141	668,557		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	582,801	4,141	668,557		200.00

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	8,066,428	8,066,428			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	11,292,208		11,292,208		2.00
4.00 00400	EMPLOYEE BENEFITS	19,504,685	258,118	3,912	19,766,715	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	61,437,205	299,419	4,223,199	2,020,889	67,980,712
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	5,954,959	2,009,623	337,643	473,083	8,775,308
8.00 00800	LAUNDRY & LINEN SERVICE	210,153	0	296	0	210,449
9.00 00900	HOUSEKEEPING	2,146,627	129,154	12,734	418,290	2,706,805
10.00 01000	DIETARY	734,482	55,055	74,196	80,653	944,386
11.00 01100	CAFETERIA	772,951	336,260	0	492,792	1,602,003
13.00 01300	NURSING ADMINISTRATION	1,800,948	269,870	4,107	329,068	2,403,993
14.00 01400	CENTRAL SERVICES & SUPPLY	778,279	97,640	739,139	118,688	1,733,746
15.00 01500	PHARMACY	2,942,271	132,857	233,910	686,482	3,995,520
16.00 01600	MEDICAL RECORDS & LIBRARY	2,912,959	148,160	3,895	704,511	3,769,525
17.00 01700	SOCIAL SERVICE	1,345,736	39,411	664	299,571	1,685,382
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	8,063,973	103,761	2,074	1,949,437	10,119,245
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	9,622,184	934,228	98,525	2,209,163	12,864,100
31.00 03100	INTENSIVE CARE UNIT	2,130,996	129,494	161,159	517,573	2,939,222
34.00 03400	SURGICAL INTENSIVE CARE UNIT	1,584,077	0	56,624	402,354	2,043,055
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	5,523,916	514,385	1,286,021	1,119,691	8,444,013
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,612,082	288,309	474,328	889,467	6,264,186
55.00 05500	RADIOLOGY-THERAPEUTIC	5,256,037	488,615	1,815,943	598,798	8,159,393
56.00 05600	RADIOISOTOPE	520,898	15,115	717	121,036	657,766
57.00 05700	CT SCAN	744,209	25,015	620,306	152,482	1,542,012
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	489,173	56,150	195,916	97,574	838,813
60.00 06000	LABORATORY	6,387,211	273,875	407,732	868,317	7,937,135
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	1,960,662	11,034	21,420	0	1,993,116
64.00 06400	INTRAVENOUS THERAPY	2,471,562	238,734	539	603,442	3,314,277
65.00 06500	RESPIRATORY THERAPY	908,336	38,580	29,721	231,408	1,208,045
66.00 06600	PHYSICAL THERAPY	1,261,326	55,130	2,996	248,930	1,568,382
69.00 06900	ELECTROCARDIOLOGY	442,538	9,673	58,955	102,694	613,860
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,234,048	0	0	0	14,234,048
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	77,548,488	0	0	0	77,548,488
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.01 03951	HOSPITAL NUTRITION	973,667	25,808	1,456	248,699	1,249,630
76.02 03952	PAIN MANAGEMENT	0	0	0	0	0
76.03 03954	INFUSION CENTER	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	5,807,154	820,491	32,451	1,473,341	8,133,437
91.00 09100	EMERGENCY	1,930,228	126,131	60,252	354,835	2,471,446
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	272,372,656	7,930,095	10,960,830	17,813,268	269,951,498
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	195,123	15,908	0	16,447	227,478
191.00 19100	RESEARCH	371,132	26,224	1,250	95,969	494,575
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	39,232,907	94,201	330,128	1,841,031	41,498,267
200.00	Cross Foot Adjustments	0	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	312,171,818	8,066,428	11,292,208	19,766,715	312,171,818

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet B  
Part I  
Date/Time Prepared:  
11/16/2013 12:00 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	67,980,712					5.00
6.00	00600	0	0				6.00
7.00	00700	2,442,967	0	11,218,275			7.00
8.00	00800	58,587	0	0	269,036		8.00
9.00	00900	753,550	0	263,468	0	3,723,823	9.00
10.00	01000	262,909	0	112,309	0	38,177	10.00
11.00	01100	445,983	0	685,957	0	233,175	11.00
13.00	01300	669,250	0	550,523	0	187,137	13.00
14.00	01400	482,659	0	199,181	0	67,707	14.00
15.00	01500	1,112,317	0	271,022	0	92,127	15.00
16.00	01600	1,049,402	0	302,240	0	102,739	16.00
17.00	01700	469,195	0	80,397	613	27,329	17.00
18.00	01850	2,817,107	0	211,668	1,108	71,952	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	3,581,250	0	1,905,788	83,472	647,828	30.00
31.00	03100	818,253	0	264,162	11,884	89,795	31.00
34.00	03400	568,768	0	0	0	0	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	2,350,737	0	1,049,324	42,152	356,692	50.00
54.00	05400	1,743,893	0	588,139	52,907	199,924	54.00
55.00	05500	2,271,502	0	996,753	20,669	338,822	55.00
56.00	05600	183,116	0	30,833	0	10,481	56.00
57.00	05700	429,282	0	51,029	0	17,346	57.00
58.00	05800	233,518	0	114,545	0	38,937	58.00
60.00	06000	2,209,627	0	558,694	0	189,915	60.00
63.00	06300	554,866	0	22,508	0	7,651	63.00
64.00	06400	922,665	0	487,007	27,579	165,546	64.00
65.00	06500	336,309	0	78,701	0	26,753	65.00
66.00	06600	436,623	0	112,463	6,365	38,229	66.00
69.00	06900	170,893	0	19,733	975	6,708	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	3,962,631	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	21,588,906	0	0	0	0	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	347,886	0	52,647	0	17,896	76.01
76.02	03952	0	0	0	0	0	76.02
76.03	03954	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	2,264,276	0	1,673,769	9,426	568,957	90.00
91.00	09100	688,028	0	257,301	11,886	87,463	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		56,226,955	0	10,940,161	269,036	3,629,286	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	63,328	0	32,452	0	11,031	190.00
191.00	19100	137,685	0	53,495	0	18,184	191.00
194.00	07950	11,552,744	0	192,167	0	65,322	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		67,980,712	0	11,218,275	269,036	3,723,823	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet B  
Part I  
Date/Time Prepared:  
11/16/2013 12:00 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	1,357,781					10.00
11.00	01100	0	2,967,118				11.00
13.00	01300	0	62,056	3,872,959			13.00
14.00	01400	0	34,661	0	2,517,954		14.00
15.00	01500	0	107,793	0	0	5,578,779	15.00
16.00	01600	0	159,314	0	0	0	16.00
17.00	01700	0	65,690	0	0	0	17.00
18.00	01850	0	328,248	0	0	0	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,042,369	383,252	1,625,281	0	0	30.00
31.00	03100	67,879	70,297	298,115	0	0	31.00
34.00	03400	0	63,575	269,607	0	0	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	201,237	853,399	0	0	50.00
54.00	05400	0	145,716	0	0	0	54.00
55.00	05500	0	99,400	0	0	0	55.00
56.00	05600	0	14,899	0	0	0	56.00
57.00	05700	0	22,677	0	0	0	57.00
58.00	05800	0	12,576	0	0	0	58.00
60.00	06000	0	167,796	0	0	0	60.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	226,584	103,599	439,340	0	0	64.00
65.00	06500	0	36,841	0	0	0	65.00
66.00	06600	0	46,710	0	0	0	66.00
69.00	06900	0	13,892	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	2,517,954	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	5,578,779	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	0	50,313	0	0	0	76.01
76.02	03952	0	0	0	0	0	76.02
76.03	03954	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	254,305	95,641	0	0	90.00
91.00	09100	20,949	68,756	291,576	0	0	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		1,357,781	2,513,603	3,872,959	2,517,954	5,578,779	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	5,821	0	0	0	190.00
191.00	19100	0	14,187	0	0	0	191.00
194.00	07950	0	433,507	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,357,781	2,967,118	3,872,959	2,517,954	5,578,779	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet B  
Part I  
Date/Time Prepared:  
11/16/2013 12:00 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	17.00	18.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600	5,383,220					16.00
17.00	01700	0	2,328,606				17.00
18.00	01850	0	0	13,549,328			18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	119,003	51,486	299,510	22,603,339	0	30.00
31.00	03100	20,484	8,862	51,555	4,640,508	0	31.00
34.00	03400	19,441	8,411	48,929	3,021,786	0	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	349,794	151,335	880,368	14,679,051	0	50.00
54.00	05400	218,125	94,370	548,981	9,856,241	0	54.00
55.00	05500	342,727	148,277	862,579	13,240,122	0	55.00
56.00	05600	25,574	11,064	64,366	998,099	0	56.00
57.00	05700	419,802	181,623	1,056,563	3,720,334	0	57.00
58.00	05800	72,934	31,554	183,563	1,526,440	0	58.00
60.00	06000	345,363	149,418	869,215	12,427,163	0	60.00
63.00	06300	41,966	18,156	105,621	2,743,884	0	63.00
64.00	06400	143,078	61,901	360,100	6,251,676	0	64.00
65.00	06500	10,568	4,572	26,597	1,728,386	0	65.00
66.00	06600	14,315	6,193	36,029	2,265,309	0	66.00
69.00	06900	28,042	12,132	70,576	936,811	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	170,734	73,866	429,705	21,388,938	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	3,001,688	1,298,262	7,555,451	116,571,574	0	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	3,637	1,573	9,153	1,732,735	0	76.01
76.02	03952	0	0	0	0	0	76.02
76.03	03954	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	29,184	12,626	73,450	13,115,071	0	90.00
91.00	09100	6,761	2,925	17,017	3,924,108	0	91.00
92.00	09200					0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		5,383,220	2,328,606	13,549,328	257,371,575	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	340,110	0	190.00
191.00	19100	0	0	0	718,126	0	191.00
194.00	07950	0	0	0	53,742,007	0	194.00
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		5,383,220	2,328,606	13,549,328	312,171,818	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet B  
Part I  
Date/Time Prepared:  
11/16/2013 12:00 pm

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
6.00	00600 MAINTENANCE & REPAIRS		6.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)		18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS	22,603,339	30.00
31.00	03100 INTENSIVE CARE UNIT	4,640,508	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	3,021,786	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	14,679,051	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	9,856,241	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	13,240,122	55.00
56.00	05600 RADIOISOTOPE	998,099	56.00
57.00	05700 CT SCAN	3,720,334	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,526,440	58.00
60.00	06000 LABORATORY	12,427,163	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,743,884	63.00
64.00	06400 INTRAVENOUS THERAPY	6,251,676	64.00
65.00	06500 RESPIRATORY THERAPY	1,728,386	65.00
66.00	06600 PHYSICAL THERAPY	2,265,309	66.00
69.00	06900 ELECTROCARDIOLOGY	936,811	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21,388,938	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	116,571,574	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	76.00
76.01	03951 HOSPITAL NUTRITION	1,732,735	76.01
76.02	03952 PAIN MANAGEMENT	0	76.02
76.03	03954 INFUSION CENTER	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000 CLINIC	13,115,071	90.00
91.00	09100 EMERGENCY	3,924,108	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	257,371,575	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	340,110	190.00
191.00	19100 RESEARCH	718,126	191.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	53,742,007	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	312,171,818	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet B  
Part II  
Date/Time Prepared:  
11/16/2013 12:00 pm

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	258,118	3,912	262,030	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	299,419	4,223,199	4,522,618	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	2,009,623	337,643	2,347,266	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	296	296	8.00
9.00 00900	HOUSEKEEPING	0	129,154	12,734	141,888	9.00
10.00 01000	DIETARY	0	55,055	74,196	129,251	10.00
11.00 01100	CAFETERIA	0	336,260	0	336,260	11.00
13.00 01300	NURSING ADMINISTRATION	0	269,870	4,107	273,977	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	97,640	739,139	836,779	14.00
15.00 01500	PHARMACY	0	132,857	233,910	366,767	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	148,160	3,895	152,055	16.00
17.00 01700	SOCIAL SERVICE	0	39,411	664	40,075	17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	103,761	2,074	105,835	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	934,228	98,525	1,032,753	30.00
31.00 03100	INTENSIVE CARE UNIT	0	129,494	161,159	290,653	31.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	56,624	56,624	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	514,385	1,286,021	1,800,406	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	288,309	474,328	762,637	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	488,615	1,815,943	2,304,558	55.00
56.00 05600	RADIOISOTOPE	0	15,115	717	15,832	56.00
57.00 05700	CT SCAN	0	25,015	620,306	645,321	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	56,150	195,916	252,066	58.00
60.00 06000	LABORATORY	0	273,875	407,732	681,607	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	11,034	21,420	32,454	63.00
64.00 06400	INTRAVENOUS THERAPY	0	238,734	539	239,273	64.00
65.00 06500	RESPIRATORY THERAPY	0	38,580	29,721	68,301	65.00
66.00 06600	PHYSICAL THERAPY	0	55,130	2,996	58,126	66.00
69.00 06900	ELECTROCARDIOLOGY	0	9,673	58,955	68,628	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
76.01 03951	HOSPITAL NUTRITION	0	25,808	1,456	27,264	76.01
76.02 03952	PAIN MANAGEMENT	0	0	0	0	76.02
76.03 03954	INFUSION CENTER	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	820,491	32,451	852,942	90.00
91.00 09100	EMERGENCY	0	126,131	60,252	186,383	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	7,930,095	10,960,830	18,890,925	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,908	0	15,908	190.00
191.00 19100	RESEARCH	0	26,224	1,250	27,474	191.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	94,201	330,128	424,329	194.00
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)	0	8,066,428	11,292,208	19,358,636	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet B  
Part II  
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	4,549,405					5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700 OPERATION OF PLANT	163,493	0	2,517,030			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	3,921	0	0	4,217		8.00
9.00	00900 HOUSEKEEPING	50,430	0	59,114	0	256,976	9.00
10.00	01000 DIETARY	17,595	0	25,199	0	2,635	10.00
11.00	01100 CAFETERIA	29,847	0	153,907	0	16,091	11.00
13.00	01300 NURSING ADMINISTRATION	44,789	0	123,520	0	12,914	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	32,301	0	44,690	0	4,672	14.00
15.00	01500 PHARMACY	74,441	0	60,809	0	6,358	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	70,230	0	67,813	0	7,090	16.00
17.00	01700 SOCIAL SERVICE	31,400	0	18,039	10	1,886	17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	188,532	0	47,492	17	4,965	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	239,671	0	427,602	1,309	44,705	30.00
31.00	03100 INTENSIVE CARE UNIT	54,761	0	59,270	186	6,197	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	38,064	0	0	0	0	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	157,320	0	235,435	661	24,615	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	116,708	0	131,960	829	13,796	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	152,018	0	223,640	324	23,382	55.00
56.00	05600 RADIOISOTOPE	12,255	0	6,918	0	723	56.00
57.00	05700 CT SCAN	28,729	0	11,449	0	1,197	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	15,628	0	25,700	0	2,687	58.00
60.00	06000 LABORATORY	147,877	0	125,353	0	13,106	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	37,134	0	5,050	0	528	63.00
64.00	06400 INTRAVENOUS THERAPY	61,748	0	109,269	432	11,424	64.00
65.00	06500 RESPIRATORY THERAPY	22,507	0	17,658	0	1,846	65.00
66.00	06600 PHYSICAL THERAPY	29,221	0	25,233	100	2,638	66.00
69.00	06900 ELECTROCARDIOLOGY	11,437	0	4,427	15	463	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	265,195	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,444,685	0	0	0	0	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951 HOSPITAL NUTRITION	23,282	0	11,812	0	1,235	76.01
76.02	03952 PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954 INFUSION CENTER	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	151,534	0	375,541	148	39,263	90.00
91.00	09100 EMERGENCY	46,046	0	57,730	186	6,036	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,762,799	0	2,454,630	4,217	250,452	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,238	0	7,281	0	761	190.00
191.00	19100 RESEARCH	9,214	0	12,003	0	1,255	191.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	773,154	0	43,116	0	4,508	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	4,549,405	0	2,517,030	4,217	256,976	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet 8  
Part II  
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	175,749					10.00
11.00	01100	0	542,637				11.00
13.00	01300	0	11,349	470,911			13.00
14.00	01400	0	6,339	0	926,354		14.00
15.00	01500	0	19,714	0	0	537,188	15.00
16.00	01600	0	29,136	0	0	0	16.00
17.00	01700	0	12,014	0	0	0	17.00
18.00	01850	0	60,031	0	0	0	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	134,922	70,090	197,617	0	0	30.00
31.00	03100	8,786	12,856	36,248	0	0	31.00
34.00	03400	0	11,627	32,781	0	0	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	36,803	103,764	0	0	50.00
54.00	05400	0	26,649	0	0	0	54.00
55.00	05500	0	18,179	0	0	0	55.00
56.00	05600	0	2,725	0	0	0	56.00
57.00	05700	0	4,147	0	0	0	57.00
58.00	05800	0	2,300	0	0	0	58.00
60.00	06000	0	30,687	0	0	0	60.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	29,329	18,947	53,419	0	0	64.00
65.00	06500	0	6,738	0	0	0	65.00
66.00	06600	0	8,543	0	0	0	66.00
69.00	06900	0	2,541	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	926,354	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	537,188	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	0	9,201	0	0	0	76.01
76.02	03952	0	0	0	0	0	76.02
76.03	03954	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	46,508	11,629	0	0	90.00
91.00	09100	2,712	12,574	35,453	0	0	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		175,749	459,698	470,911	926,354	537,188	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	1,064	0	0	0	190.00
191.00	19100	0	2,595	0	0	0	191.00
194.00	07950	0	79,280	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		175,749	542,637	470,911	926,354	537,188	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet B  
Part II  
Date/Time Prepared:  
11/16/2013 12:00 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	17.00	18.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600	335,662					16.00
17.00	01700	0	107,395				17.00
18.00	01850	0	0	432,712			18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	7,415	2,382	9,575	2,197,346	0	30.00
31.00	03100	1,276	410	1,648	479,151	0	31.00
34.00	03400	1,211	389	1,564	147,593	0	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	21,794	7,000	28,145	2,430,785	0	50.00
54.00	05400	13,591	4,365	17,551	1,099,876	0	54.00
55.00	05500	21,354	6,859	27,577	2,785,828	0	55.00
56.00	05600	1,593	512	2,058	44,220	0	56.00
57.00	05700	26,156	8,401	33,778	761,199	0	57.00
58.00	05800	4,544	1,460	5,868	311,546	0	58.00
60.00	06000	21,518	6,912	27,789	1,066,359	0	60.00
63.00	06300	2,615	840	3,377	81,998	0	63.00
64.00	06400	8,915	2,863	11,512	555,130	0	64.00
65.00	06500	658	211	850	121,836	0	65.00
66.00	06600	892	286	1,152	129,491	0	66.00
69.00	06900	1,747	561	2,256	93,436	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	10,638	3,417	13,738	1,219,342	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	187,279	59,735	241,089	2,469,976	0	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	227	73	293	76,684	0	76.01
76.02	03952	0	0	0	0	0	76.02
76.03	03954	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	1,818	584	2,348	1,501,844	0	90.00
91.00	09100	421	135	544	352,923	0	91.00
92.00	09200					0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		335,662	107,395	432,712	17,926,563	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	29,470	0	190.00
191.00	19100	0	0	0	53,813	0	191.00
194.00	07950	0	0	0	1,348,790	0	194.00
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		335,662	107,395	432,712	19,358,636	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
6.00	00600 MAINTENANCE & REPAIRS		6.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)		18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEOIATRICS	2,197,346	30.00
31.00	03100 INTENSIVE CARE UNIT	479,151	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	147,593	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	2,430,785	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,099,876	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	2,785,828	55.00
56.00	05600 RADIOISOTOPE	44,220	56.00
57.00	05700 CT SCAN	761,199	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	311,546	58.00
60.00	06000 LABORATORY	1,066,359	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	81,998	63.00
64.00	06400 INTRAVENOUS THERAPY	555,130	64.00
65.00	06500 RESPIRATORY THERAPY	121,836	65.00
66.00	06600 PHYSICAL THERAPY	129,491	66.00
69.00	06900 ELECTROCARDIOLOGY	93,436	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,219,342	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,469,976	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	76.00
76.01	03951 HOSPITAL NUTRITION	76,684	76.01
76.02	03952 PAIN MANAGEMENT	0	76.02
76.03	03954 INFUSION CENTER	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000 CLINIC	1,501,844	90.00
91.00	09100 EMERGENCY	352,923	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	17,926,563	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	29,470	190.00
191.00	19100 RESEARCH	53,813	191.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	1,348,790	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	19,358,636	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet B-1

Date/Time Prepared:  
11/16/2013 12:00 PM

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 CAP REL COSTS-BLDG & FIXT	213,475						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		11,292,505					2.00
4.00 00400 EMPLOYEE BENEFITS	6,831	3,912	67,164,655				4.00
5.00 00500 ADMINISTRATIVE & GENERAL	7,924	4,223,312	6,866,720	-67,980,712	244,191,106		5.00
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0		6.00
7.00 00700 OPERATION OF PLANT	53,184	337,652	1,607,473	0	8,775,308		7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	296	0	0	210,449		8.00
9.00 00900 HOUSEKEEPING	3,418	12,734	1,421,295	0	2,706,805		9.00
10.00 01000 DIETARY	1,457	74,198	274,047	0	944,386		10.00
11.00 01100 CAFETERIA	8,899	0	1,674,443	0	1,602,003		11.00
13.00 01300 NURSING ADMINISTRATION	7,142	4,107	1,118,130	0	2,403,993		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	2,584	739,158	403,286	0	1,733,746		14.00
15.00 01500 PHARMACY	3,516	233,916	2,332,577	0	3,995,520		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	3,921	3,895	2,393,838	0	3,769,525		16.00
17.00 01700 SOCIAL SERVICE	1,043	664	1,017,903	0	1,685,382		17.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	2,746	2,074	6,623,934	0	10,119,245		18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	24,724	98,528	7,506,374	0	12,864,100		30.00
31.00 03100 INTENSIVE CARE UNIT	3,427	161,163	1,758,646	0	2,939,222		31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	56,625	1,367,146	0	2,043,055		34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	13,613	1,286,054	3,804,563	0	8,444,013		50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	7,630	474,340	3,022,295	0	6,264,186		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	12,931	1,815,990	2,034,637	0	8,159,393		55.00
56.00 05600 RADIOISOTOPE	400	717	411,264	0	657,766		56.00
57.00 05700 CT SCAN	662	620,322	518,115	0	1,542,012		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1,486	195,921	331,544	0	838,813		58.00
60.00 06000 LABORATORY	7,248	407,743	2,950,429	0	7,937,135		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	292	21,421	0	0	1,993,116		63.00
64.00 06400 INTRAVENOUS THERAPY	6,318	539	2,050,419	0	3,314,277		64.00
65.00 06500 RESPIRATORY THERAPY	1,021	29,722	786,294	0	1,208,045		65.00
66.00 06600 PHYSICAL THERAPY	1,459	2,996	845,833	0	1,568,382		66.00
69.00 06900 ELECTROCARDIOLOGY	256	58,957	348,940	0	613,860		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	14,234,048		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	77,548,488		73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0		76.00
76.01 03951 HOSPITAL NUTRITION	683	1,456	845,046	0	1,249,630		76.01
76.02 03952 PAIN MANAGEMENT	0	0	0	0	0		76.02
76.03 03954 INFUSION CENTER	0	0	0	0	0		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	21,714	32,452	5,006,223	0	8,133,437		90.00
91.00 09100 EMERGENCY	3,338	60,254	1,205,683	0	2,471,446		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)							92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300 INTEREST EXPENSE							113.00
118.00 11800 SUBTOTALS (SUM OF LINES 1-117)	209,867	10,961,118	60,527,097	-67,980,712	201,970,786		118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	421	0	55,886	0	227,478		190.00
191.00 19100 RESEARCH	694	1,250	326,089	0	494,575		191.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	2,493	330,137	6,255,583	0	41,498,267		194.00
200.00 Cross Foot Adjustments							200.00
201.00 Negative Cost Centers							201.00
202.00 Cost to be allocated (per wkst. B, Part I)	8,066,428	11,292,208	19,766,715		67,980,712		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	37.786289	0.999974	0.294302		0.278391		203.00
204.00 Cost to be allocated (per wkst. B, Part II)			262,030		4,549,405		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.003901		0.018631		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet B-1

Date/Time Prepared:  
11/16/2013 12:00 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQARE FEET)	OPERATION OF PLANT (SQARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	198,720					6.00
7.00	00700	53,184	145,536				7.00
8.00	00800	0	0	540,469			8.00
9.00	00900	3,418	3,418	0	142,118		9.00
10.00	01000	1,457	1,457	0	1,457	39,406	10.00
11.00	01100	8,899	8,899	0	8,899	0	11.00
13.00	01300	7,142	7,142	0	7,142	0	13.00
14.00	01400	2,584	2,584	0	2,584	0	14.00
15.00	01500	3,516	3,516	0	3,516	0	15.00
16.00	01600	3,921	3,921	0	3,921	0	16.00
17.00	01700	1,043	1,043	1,231	1,043	0	17.00
18.00	01850	2,746	2,746	2,226	2,746	0	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	24,724	24,724	167,693	24,724	30,252	30.00
31.00	03100	3,427	3,427	23,873	3,427	1,970	31.00
34.00	03400	0	0	0	0	0	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	13,613	13,613	84,680	13,613	0	50.00
54.00	05400	7,630	7,630	106,285	7,630	0	54.00
55.00	05500	12,931	12,931	41,522	12,931	0	55.00
56.00	05600	400	400	0	400	0	56.00
57.00	05700	662	662	0	662	0	57.00
58.00	05800	1,486	1,486	0	1,486	0	58.00
60.00	06000	7,248	7,248	0	7,248	0	60.00
63.00	06300	292	292	0	292	0	63.00
64.00	06400	6,318	6,318	55,403	6,318	6,576	64.00
65.00	06500	1,021	1,021	0	1,021	0	65.00
66.00	06600	1,459	1,459	12,786	1,459	0	66.00
69.00	06900	256	256	1,958	256	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	683	683	0	683	0	76.01
76.02	03952	0	0	0	0	0	76.02
76.03	03954	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	21,714	21,714	18,935	21,714	0	90.00
91.00	09100	3,338	3,338	23,877	3,338	608	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		195,112	141,928	540,469	138,510	39,406	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	421	421	0	421	0	190.00
191.00	19100	694	694	0	694	0	191.00
194.00	07950	2,493	2,493	0	2,493	0	194.00
200.00							200.00
201.00							201.00
202.00		0	11,218,275	269,036	3,723,823	1,357,781	202.00
203.00		0.000000	77.082474	0.497782	26.202332	34.456200	203.00
204.00		0	2,517,030	4,217	256,976	175,749	204.00
205.00		0.000000	17.294896	0.007802	1.808188	4.459955	205.00

Cost Center Description		CAFETERIA (ASSIGNED TIME)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,789,794					11.00
13.00	01300	37,433	550,892				13.00
14.00	01400	20,908	0	1,000			14.00
15.00	01500	65,022	0	0	1,000		15.00
16.00	01600	96,100	0	0	0	1,110,651,403	16.00
17.00	01700	39,625	0	0	0	0	17.00
18.00	01850	198,002	0	0	0	0	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	231,181	231,181	0	0	24,551,983	30.00
31.00	03100	42,404	42,404	0	0	4,226,181	31.00
34.00	03400	38,349	38,349	0	0	4,010,926	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	121,388	121,388	0	0	72,167,209	50.00
54.00	05400	87,897	0	0	0	45,002,166	54.00
55.00	05500	59,959	0	0	0	70,708,996	55.00
56.00	05600	8,987	0	0	0	5,276,297	56.00
57.00	05700	13,679	0	0	0	86,610,660	57.00
58.00	05800	7,586	0	0	0	15,047,342	58.00
60.00	06000	101,216	0	0	0	71,252,993	60.00
63.00	06300	0	0	0	0	8,658,133	63.00
64.00	06400	62,492	62,492	0	0	29,518,810	64.00
65.00	06500	22,223	0	0	0	2,180,236	65.00
66.00	06600	28,176	0	0	0	2,953,464	66.00
69.00	06900	8,380	0	0	0	5,785,407	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	1,000	0	35,224,639	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	1,000	619,309,754	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	30,349	0	0	0	750,280	76.01
76.02	03952	0	0	0	0	0	76.02
76.03	03954	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	153,399	13,604	0	0	6,020,994	90.00
91.00	09100	41,474	41,474	0	0	1,394,933	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		1,516,229	550,892	1,000	1,000	1,110,651,403	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	3,511	0	0	0	0	190.00
191.00	19100	8,558	0	0	0	0	191.00
194.00	07950	261,496	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		2,967,118	3,872,959	2,517,954	5,578,779	5,383,220	202.00
203.00		1.657799	7.030342	2,517.954000	5,578.779000	0.004847	203.00
204.00		542,637	470,911	926,354	537,188	335,662	204.00
205.00		0.303184	0.854815	926.354000	537.188000	0.000302	205.00

Cost Center Description	SOCIAL SERVICE  (GROSS CHARGES)	OTHER GENERAL SERVICE (SPECIFY) (GROSS CHARGES)		
		17.00	18.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00 00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00 00400	EMPLOYEE BENEFITS			4.00
5.00 00500	ADMINISTRATIVE & GENERAL			5.00
6.00 00600	MAINTENANCE & REPAIRS			6.00
7.00 00700	OPERATION OF PLANT			7.00
8.00 00800	LAUNDRY & LINEN SERVICE			8.00
9.00 00900	HOUSEKEEPING			9.00
10.00 01000	DIETARY			10.00
11.00 01100	CAFETERIA			11.00
13.00 01300	NURSING ADMINISTRATION			13.00
14.00 01400	CENTRAL SERVICES & SUPPLY			14.00
15.00 01500	PHARMACY			15.00
16.00 01600	MEDICAL RECORDS & LIBRARY			16.00
17.00 01700	SOCIAL SERVICE	1,110,651,403		17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	1,110,651,403	18.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 03000	ADULTS & PEDIATRICS	24,551,983	24,551,983	30.00
31.00 03100	INTENSIVE CARE UNIT	4,226,181	4,226,181	31.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	4,010,926	4,010,926	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000	OPERATING ROOM	72,167,209	72,167,209	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	45,002,166	45,002,166	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	70,708,996	70,708,996	55.00
56.00 05600	RADIOISOTOPE	5,276,297	5,276,297	56.00
57.00 05700	CT SCAN	86,610,660	86,610,660	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	15,047,342	15,047,342	58.00
60.00 06000	LABORATORY	71,252,993	71,252,993	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	8,658,133	8,658,133	63.00
64.00 06400	INTRAVENOUS THERAPY	29,518,810	29,518,810	64.00
65.00 06500	RESPIRATORY THERAPY	2,180,236	2,180,236	65.00
66.00 06600	PHYSICAL THERAPY	2,953,464	2,953,464	66.00
69.00 06900	ELECTROCARDIOLOGY	5,785,407	5,785,407	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,224,639	35,224,639	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	619,309,754	619,309,754	73.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01 03951	HOSPITAL NUTRITION	750,280	750,280	76.01
76.02 03952	PAIN MANAGEMENT	0	0	76.02
76.03 03954	INFUSION CENTER	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000	CLINIC	6,020,994	6,020,994	90.00
91.00 09100	EMERGENCY	1,394,933	1,394,933	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00 11300	INTEREST EXPENSE			113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	1,110,651,403	1,110,651,403	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00 19100	RESEARCH	0	0	191.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
200.00	Cross Foot Adjustments			200.00
201.00	Negative Cost Centers			201.00
202.00	Cost to be allocated (per wkst. B, Part I)	2,328,606	13,549,328	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	0.002097	0.012199	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	107,395	432,712	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.000097	0.000390	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
11/16/2013 12:00 pm

Cost Center Description	Total Cost (from wkst. 8, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	PPS
			Total Costs	RCE Disallowance		
			1.00	2.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	22,603,339		22,603,339	0	22,603,339	30.00
31.00 03100 INTENSIVE CARE UNIT	4,640,508		4,640,508	0	4,640,508	31.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	3,021,786		3,021,786	0	3,021,786	34.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	14,679,051		14,679,051	0	14,679,051	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	9,856,241		9,856,241	0	9,856,241	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	13,240,122		13,240,122	0	13,240,122	55.00
56.00 05600 RADIOISOTOPE	998,099		998,099	0	998,099	56.00
57.00 05700 CT SCAN	3,720,334		3,720,334	0	3,720,334	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1,526,440		1,526,440	0	1,526,440	58.00
60.00 06000 LABORATORY	12,427,163		12,427,163	0	12,427,163	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	2,743,884		2,743,884	0	2,743,884	63.00
64.00 06400 INTRAVENOUS THERAPY	6,251,676		6,251,676	0	6,251,676	64.00
65.00 06500 RESPIRATORY THERAPY	1,728,386	0	1,728,386	0	1,728,386	65.00
66.00 06600 PHYSICAL THERAPY	2,265,309	0	2,265,309	0	2,265,309	66.00
69.00 06900 ELECTROCARDIOLOGY	936,811		936,811	0	936,811	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21,388,938		21,388,938	0	21,388,938	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	116,571,574		116,571,574	0	116,571,574	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.01 03951 HOSPITAL NUTRITION	1,732,735		1,732,735	0	1,732,735	76.01
76.02 03952 PAIN MANAGEMENT	0		0	0	0	76.02
76.03 03954 INFUSION CENTER	0		0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	13,115,071		13,115,071	0	13,115,071	90.00
91.00 09100 EMERGENCY	3,924,108		3,924,108	4,141	3,928,249	91.00
92.00 09200 OBSERVATION BEDS (NON-OISTINCT PART)	1,979,234		1,979,234		1,979,234	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	259,350,809	0	259,350,809	4,141	259,354,950	200.00
201.00 Less Observation Beds	1,979,234		1,979,234		1,979,234	201.00
202.00 Total (see instructions)	257,371,575	0	257,371,575	4,141	257,375,716	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
11/16/2013 12:00 PM

Cost Center Description	Title XVIII			Hospital	PPS	TEFRA Inpatient Ratio	
	Charges			Cost or Other 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	23,155,895		23,155,895		30.00
31.00	03100	INTENSIVE CARE UNIT	4,226,181		4,226,181		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,010,926		4,010,926		34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	38,421,012	33,746,197	72,167,209	0.203403	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,569,545	37,432,621	45,002,166	0.219017	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,705,250	67,003,746	70,708,996	0.187248	55.00
56.00	05600	RADIOISOTOPE	278,924	4,997,373	5,276,297	0.189167	56.00
57.00	05700	CT SCAN	5,854,668	80,755,992	86,610,660	0.042955	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,635,607	13,411,735	15,047,342	0.101443	58.00
60.00	06000	LABORATORY	15,868,350	55,384,643	71,252,993	0.174409	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,735,578	2,922,555	8,658,133	0.316914	63.00
64.00	06400	INTRAVENOUS THERAPY	56,764	29,462,046	29,518,810	0.211786	64.00
65.00	06500	RESPIRATORY THERAPY	1,562,646	617,590	2,180,236	0.792752	65.00
66.00	06600	PHYSICAL THERAPY	1,889,451	1,064,013	2,953,464	0.767001	66.00
69.00	06900	ELECTROCARDIOLOGY	1,326,777	4,458,630	5,785,407	0.161927	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,799,111	15,425,528	35,224,639	0.607215	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,703,397	536,606,357	619,309,754	0.188228	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.00
76.01	03951	HOSPITAL NUTRITION	24,852	725,428	750,280	2.309451	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0.000000	76.02
76.03	03954	INFUSION CENTER	0	0	0	0.000000	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	633,320	5,387,674	6,020,994	2.178224	90.00
91.00	09100	EMERGENCY	171,902	1,223,031	1,394,933	2.813116	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	536,798	859,290	1,396,088	1.417700	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	219,166,954	891,484,449	1,110,651,403		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	219,166,954	891,484,449	1,110,651,403		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
11/16/2013 12:00 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000				30.00
31.00	03100				31.00
34.00	03400				34.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	0.203403			50.00
54.00	05400	0.219017			54.00
55.00	05500	0.187248			55.00
56.00	05600	0.189167			56.00
57.00	05700	0.042955			57.00
58.00	05800	0.101443			58.00
60.00	06000	0.174409			60.00
63.00	06300	0.316914			63.00
64.00	06400	0.211786			64.00
65.00	06500	0.792752			65.00
66.00	06600	0.767001			66.00
69.00	06900	0.161927			69.00
70.00	07000	0.000000			70.00
71.00	07100	0.607215			71.00
72.00	07200	0.000000			72.00
73.00	07300	0.188228			73.00
76.00	03950	0.000000			76.00
76.01	03951	2.309451			76.01
76.02	03952	0.000000			76.02
76.03	03954	0.000000			76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	2.178224			90.00
91.00	09100	2.816084			91.00
92.00	09200	1.417700			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
200.00					200.00
201.00					201.00
202.00					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
11/16/2013 12:00 pm

Cost Center Description		Total Cost (from wkst. 8, Part I, col. 26)	Therapy Limit Adj.	Hospital		Cost
				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	22,603,339		22,603,339	0	0 30.00
31.00	03100 INTENSIVE CARE UNIT	4,640,508		4,640,508	0	0 31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	3,021,786		3,021,786	0	0 34.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	14,679,051		14,679,051	0	0 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	9,856,241		9,856,241	0	0 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	13,240,122		13,240,122	0	0 55.00
56.00	05600 RADIOISOTOPE	998,099		998,099	0	0 56.00
57.00	05700 CT SCAN	3,720,334		3,720,334	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,526,440		1,526,440	0	0 58.00
60.00	06000 LABORATORY	12,427,163		12,427,163	0	0 60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,743,884		2,743,884	0	0 63.00
64.00	06400 INTRAVENOUS THERAPY	6,251,676		6,251,676	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	1,728,386	0	1,728,386	0	0 65.00
66.00	06600 PHYSICAL THERAPY	2,265,309	0	2,265,309	0	0 66.00
69.00	06900 ELECTROCARDIOLOGY	936,811		936,811	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21,388,938		21,388,938	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	116,571,574		116,571,574	0	0 73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0 76.00
76.01	03951 HOSPITAL NUTRITION	1,732,735		1,732,735	0	0 76.01
76.02	03952 PAIN MANAGEMENT	0		0	0	0 76.02
76.03	03954 INFUSION CENTER	0		0	0	0 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	13,115,071		13,115,071	0	0 90.00
91.00	09100 EMERGENCY	3,924,108		3,924,108	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,979,234		1,979,234	0	0 92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	259,350,809	0	259,350,809	0	0 200.00
201.00	Less Observation Beds	1,979,234		1,979,234		0 201.00
202.00	Total (see instructions)	257,371,575	0	257,371,575	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
11/16/2013 12:00 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	23,155,895		23,155,895			30.00
31.00	03100 INTENSIVE CARE UNIT	4,226,181		4,226,181			31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	4,010,926		4,010,926			34.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	38,421,012	33,746,197	72,167,209	0.203403	0.000000	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	7,569,545	37,432,621	45,002,166	0.219017	0.000000	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	3,705,250	67,003,746	70,708,996	0.187248	0.000000	55.00
56.00	05600 RADIOISOTOPE	278,924	4,997,373	5,276,297	0.189167	0.000000	56.00
57.00	05700 CT SCAN	5,854,668	80,755,992	86,610,660	0.042955	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,635,607	13,411,735	15,047,342	0.101443	0.000000	58.00
60.00	06000 LABORATORY	15,868,350	55,384,643	71,252,993	0.174409	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	5,735,578	2,922,555	8,658,133	0.316914	0.000000	63.00
64.00	06400 INTRAVENOUS THERAPY	56,764	29,462,046	29,518,810	0.211786	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	1,562,646	617,590	2,180,236	0.792752	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	1,889,451	1,064,013	2,953,464	0.767001	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	1,326,777	4,458,630	5,785,407	0.161927	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19,799,111	15,425,528	35,224,639	0.607215	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	82,703,397	536,606,357	619,309,754	0.188228	0.000000	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.01	03951 HOSPITAL NUTRITION	24,852	725,428	750,280	2.309451	0.000000	76.01
76.02	03952 PAIN MANAGEMENT	0	0	0	0.000000	0.000000	76.02
76.03	03954 INFUSION CENTER	0	0	0	0.000000	0.000000	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	633,320	5,387,674	6,020,994	2.178224	0.000000	90.00
91.00	09100 EMERGENCY	171,902	1,223,031	1,394,933	2.813116	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	536,798	859,290	1,396,088	1.417700	0.000000	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	219,166,954	891,484,449	1,110,651,403			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	219,166,954	891,484,449	1,110,651,403			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
11/16/2013 12:00 pm

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
31.00	03100 INTENSIVE CARE UNIT				31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT				34.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.000000			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000			76.00
76.01	03951 HOSPITAL NUTRITION	0.000000			76.01
76.02	03952 PAIN MANAGEMENT	0.000000			76.02
76.03	03954 INFUSION CENTER	0.000000			76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet D  
Part I  
Date/Time Prepared:  
11/16/2013 12:00 pm

Cost Center Description		Capital Related Cost (from Wkst. 8, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	2,197,346	0	2,197,346	11,523	190.69	30.00
31.00	INTENSIVE CARE UNIT	479,151		479,151	1,615	296.69	31.00
34.00	SURGICAL INTENSIVE CARE UNIT	147,593		147,593	1,838	80.30	34.00
200.00	Total (lines 30-199)	2,824,090		2,824,090	14,976		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	1,488	283,747				
31.00	INTENSIVE CARE UNIT	127	37,680				
34.00	SURGICAL INTENSIVE CARE UNIT	145	11,644				
200.00	Total (lines 30-199)	1,760	333,071				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet D  
Part II  
Date/Time Prepared:  
11/16/2013 12:00 pm

Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	2,430,785	72,167,209	0.033683	2,355,804	79,351	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,099,876	45,002,166	0.024441	1,016,703	24,849	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	2,785,828	70,708,996	0.039398	273,714	10,784	55.00
56.00	05600 RADIOISOTOPE	44,220	5,276,297	0.008381	49,939	419	56.00
57.00	05700 CT SCAN	761,199	86,610,660	0.008789	729,754	6,414	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	311,546	15,047,342	0.020704	216,347	4,479	58.00
60.00	06000 LABORATORY	1,066,359	71,252,993	0.014966	2,028,979	30,366	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	81,998	8,658,133	0.009471	844,387	7,997	63.00
64.00	06400 INTRAVENOUS THERAPY	555,130	29,518,810	0.018806	9,202	173	64.00
65.00	06500 RESPIRATORY THERAPY	121,836	2,180,236	0.055882	174,821	9,769	65.00
66.00	06600 PHYSICAL THERAPY	129,491	2,953,464	0.043844	278,952	12,230	66.00
69.00	06900 ELECTROCARDIOLOGY	93,436	5,785,407	0.016150	195,263	3,153	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,219,342	35,224,639	0.034616	1,855,814	64,241	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,469,976	619,309,754	0.003988	10,515,587	41,936	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.01	03951 HOSPITAL NUTRITION	76,684	750,280	0.102207	1,993	204	76.01
76.02	03952 PAIN MANAGEMENT	0	0	0.000000	0	0	76.02
76.03	03954 INFUSION CENTER	0	0	0.000000	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	1,501,844	6,020,994	0.249435	90,502	22,574	90.00
91.00	09100 EMERGENCY	352,923	1,394,933	0.253004	27,588	6,980	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	192,407	1,396,088	0.137819	0	0	92.00
200.00	Total (lines 50-199)	15,294,880	1,079,258,401		20,665,349	325,919	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet D  
Part III  
Date/Time Prepared:  
11/16/2013 12:00 pm

Cost Center Description			Title XVIII			Hospital		Total Costs (sum of cols. 1 through 3, minus col. 4)
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	PPS	
			1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	11,523	0.00	1,488	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,615	0.00	127	0		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,838	0.00	145	0		34.00
200.00		Total (lines 30-199)	14,976		1,760	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
11/16/2013 12:00 pm

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet 0  
Part IV  
Date/Time Prepared:  
11/16/2013 12:00 pm

Cost Center Description	Title XVIII			Hospital		PPS	
	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
	6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0	72,167,209	0.000000	0.000000	2,355,804		50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	45,002,166	0.000000	0.000000	1,016,703		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	70,708,996	0.000000	0.000000	273,714		55.00
56.00 05600 RADIOISOTOPE	0	5,276,297	0.000000	0.000000	49,939		56.00
57.00 05700 CT SCAN	0	86,610,660	0.000000	0.000000	729,754		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	15,047,342	0.000000	0.000000	216,347		58.00
60.00 06000 LABORATORY	0	71,252,993	0.000000	0.000000	2,028,979		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	8,658,133	0.000000	0.000000	844,387		63.00
64.00 06400 INTRAVENOUS THERAPY	0	29,518,810	0.000000	0.000000	9,202		64.00
65.00 06500 RESPIRATORY THERAPY	0	2,180,236	0.000000	0.000000	174,821		65.00
66.00 06600 PHYSICAL THERAPY	0	2,953,464	0.000000	0.000000	278,952		66.00
69.00 06900 ELECTROCARDIOLOGY	0	5,785,407	0.000000	0.000000	195,263		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	35,224,639	0.000000	0.000000	1,855,814		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	619,309,754	0.000000	0.000000	10,515,587		73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0		76.00
76.01 03951 HOSPITAL NUTRITION	0	750,280	0.000000	0.000000	1,993		76.01
76.02 03952 PAIN MANAGEMENT	0	0	0.000000	0.000000	0		76.02
76.03 03954 INFUSION CENTER	0	0	0.000000	0.000000	0		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	6,020,994	0.000000	0.000000	90,502		90.00
91.00 09100 EMERGENCY	0	1,394,933	0.000000	0.000000	27,588		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,396,088	0.000000	0.000000	0		92.00
200.00 Total (lines 50-199)	0	1,079,258,401			20,665,349		200.00

APPORIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
11/16/2013 12:00 PM

Cost Center Description	Title XVIII			Hospital	PPS
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
	11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0	2,809,189	0		50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	3,197,903	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	6,856,963	0		55.00
56.00 05600 RADIOISOTOPE	0	472,720	0		56.00
57.00 05700 CT SCAN	0	10,391,707	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,191,596	0		58.00
60.00 06000 LABORATORY	0	716,985	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	109,604	0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	2,785,508	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	75,370	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	386,385	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	758,041	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	48,099,916	0		73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
76.01 03951 HOSPITAL NUTRITION	0	62	0		76.01
76.02 03952 PAIN MANAGEMENT	0	0	0		76.02
76.03 03954 INFUSION CENTER	0	0	0		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	0	509,640	0		90.00
91.00 09100 EMERGENCY	0	79,785	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00 Total (lines 50-199)	0	78,441,374	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet D  
Part V  
Date/Time Prepared:  
11/16/2013 12:00 pm

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.203403	2,809,189	88	0	571,397	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.219017	3,197,903	0	0	700,395	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.187248	6,856,963	0	0	1,283,953	55.00
56.00	05600 RADIOISOTOPE	0.189167	472,720	0	0	89,423	56.00
57.00	05700 CT SCAN	0.042955	10,391,707	0	0	446,376	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.101443	1,191,596	0	0	120,879	58.00
60.00	06000 LABORATORY	0.174409	716,985	4,816	0	125,049	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.316914	109,604	0	0	34,735	63.00
64.00	06400 INTRAVENOUS THERAPY	0.211786	2,785,508	4	0	589,932	64.00
65.00	06500 RESPIRATORY THERAPY	0.792752	75,370	7	0	59,750	65.00
66.00	06600 PHYSICAL THERAPY	0.767001	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.161927	386,385	0	0	62,566	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.607215	758,041	0	0	460,294	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.188228	48,099,916	416	68,423	9,053,751	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01	03951 HOSPITAL NUTRITION	2.309451	62	0	0	143	76.01
76.02	03952 PAIN MANAGEMENT	0.000000	0	0	0	0	76.02
76.03	03954 INFUSION CENTER	0.000000	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	2.178224	509,640	703	0	1,110,110	90.00
91.00	09100 EMERGENCY	2.813116	79,785	592	0	224,444	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.417700	0	0	0	0	92.00
200.00	Subtotal (see instructions)		78,441,374	6,626	68,423	14,933,197	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		78,441,374	6,626	68,423	14,933,197	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet D  
Part V  
Date/Time Prepared:  
11/16/2013 12:00 PM

Cost Center Description		Costs		Hospital	PPS
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	18	0		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600 RADIOISOTOPE	0	0		56.00
57.00	05700 CT SCAN	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000 LABORATORY	840	0		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400 INTRAVENOUS THERAPY	1	0		64.00
65.00	06500 RESPIRATORY THERAPY	6	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	78	12,879		73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.01	03951 HOSPITAL NUTRITION	0	0		76.01
76.02	03952 PAIN MANAGEMENT	0	0		76.02
76.03	03954 INFUSION CENTER	0	0		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	1,531	0		90.00
91.00	09100 EMERGENCY	1,665	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Subtotal (see instructions)	4,139	12,879		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00	Net Charges (line 200 +/- line 201)	4,139	12,879		202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet D-1

Date/Time Prepared:  
11/16/2013 12:00 pm

Cost Center Description		Title XVIII	Hospital	PPS
				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)			11,523 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			11,523 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)			10,514 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			1,488 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)			22,603,339 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)			22,603,339 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			22,603,339 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,961.58 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,918,831 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			2,918,831 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet D-1

Date/Time Prepared:  
11/16/2013 12:00 pm

Cost Center Description	Title XVIII			Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 + col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>						
43.00 INTENSIVE CARE UNIT	4,640,508	1,615	2,873.38	127	364,919	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT	3,021,786	1,838	1,644.06	145	238,389	46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
<b>Cost Center Description</b>						
					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					5,209,062	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,731,201	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>						
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					333,071	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					325,919	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					658,990	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					8,072,211	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable inpatient cost plus incentive payment (see instructions)					0	63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
87.00 Total observation bed days (see instructions)					1,009	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,961.58	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,979,234	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet D-1

Date/Time Prepared:  
11/16/2013 12:00 PM

Cost Center Description	Cost	Title XVIII		Hospital		
		Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
90.00 Capital-related cost	2,197,346	22,603,339	0.097213	1,979,234	192,407	90.00
91.00 Nursing School cost	0	22,603,339	0.000000	1,979,234	0	91.00
92.00 Allied health cost	0	22,603,339	0.000000	1,979,234	0	92.00
93.00 All other Medical Education	0	22,603,339	0.000000	1,979,234	0	93.00



CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet E  
Part A  
Date/Time Prepared:  
11/16/2013 12:00 pm

		Title XVIII		Hospital		PPS	
		before 1/1	on/after 1/1				
		1.00	1.01				
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>							
1.00	DRG Amounts Other than Outlier Payments	1,822,728					1.00
2.00	Outlier payments for discharges. (see instructions)	6,376,690					2.00
2.01	Outlier reconciliation amount	0					2.01
3.00	Managed Care Simulated Payments	0					3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	70.24					4.00
<b>Indirect Medical Education Adjustment</b>							
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00					5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00					6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00					7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00					7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.	0.00					8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00					8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00					8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)	0.00					9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00					10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00					11.00
12.00	Current year allowable FTE (see instructions)	0.00					12.00
13.00	Total allowable FTE count for the prior year.	0.00					13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00					14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00					15.00
16.00	Adjustment for residents in initial years of the program	0.00					16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00					17.00
18.00	Adjusted rolling average FTE count	0.00					18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000					19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000					20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000					21.00
22.00	IME payment adjustment (see instructions)	0					22.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>							
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00					23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00					24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00					25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000					26.00
27.00	IME payments adjustment. (see instructions)	0.000000					27.00
28.00	IME Adjustment (see instructions)	0					28.00
29.00	Total IME payment ( sum of lines 22 and 28)	0					29.00
<b>Disproportionate Share Adjustment</b>							
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.00					30.00
31.00	Percentage of Medicaid patient days to total days reported on worksheet S-2, Part I, line 24. (see instructions)	0.00					31.00
32.00	Sum of lines 30 and 31	0.00					32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00					33.00
34.00	Disproportionate share adjustment (see instructions)	0					34.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>							
40.00	Total Medicare discharges on worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0					40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0			0		41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00					42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0					43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000					44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00				0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)	0					46.00
47.00	Subtotal (see instructions)	8,199,418					47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0					48.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140100	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part A Date/Time Prepared: 11/16/2013 12:00 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		8,199,418	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		527,548	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00
57.00	Routine service other pass through costs (from wkst D, Part III, column 9, lines 30-35).		0	57.00
58.00	Ancillary service other pass through costs worksheet D, Part IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		8,726,966	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		8,726,966	61.00
62.00	Deductibles billed to program beneficiaries		119,564	62.00
63.00	Coinsurance billed to program beneficiaries		76,683	63.00
64.00	Allowable bad debts (see instructions)		89,374	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		62,562	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		8,593,281	67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0	68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	SEQUESTRATION ADJUSTMENT		-21,622	70.00
70.93	HVBP incentive payment (see instructions)		2,300	70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		0	70.94
70.95	Recovery of Accelerated Depreciation		0	70.95
70.96	Low Volume Payment-1		0	70.96
70.97	Low volume Payment-2		0	70.97
70.98	Low Volume Payment-3		0	70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		8,573,959	71.00
72.00	Interim payments		8,530,617	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)		43,342	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Operating outlier amount from worksheet E, Part A line 2 (see instructions)		0	90.00
91.00	Capital outlier from worksheet L, Part I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the Time Value of Money		0.00	94.00
95.00	Time Value of Money for operating expenses(see instructions)		0	95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0	96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140100	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/16/2013 12:00 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			17,018 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			14,933,197 2.00
3.00	PPS payments			10,509,034 3.00
4.00	Outlier payment (see instructions)			352,320 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			17,018 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			75,049 12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			75,049 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			75,049 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			58,031 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			17,018 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			10,861,354 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,999,555 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			8,878,817 27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			8,878,817 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			8,878,817 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			380,864 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			266,605 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			9,145,422 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	SEQUESTRATION ADJ			-44,766 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			9,100,656 40.00
41.00	Interim payments			8,903,044 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)			197,612 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/16/2013 12:00 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		8,530,617		8,903,044	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
<b>Program to Provider</b>						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
<b>Provider to Program</b>						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		8,530,617		8,903,044	4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
<b>Program to Provider</b>						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
<b>Provider to Program</b>						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		43,342		197,612	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		8,573,959		9,100,656	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

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

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet G

Date/Time Prepared:  
11/16/2013 12:00 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	0	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	0	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	0	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	0	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	0	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	0	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	0	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	0	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	0				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	0	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	0	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet G-1

Date/Time Prepared:  
11/16/2013 12:00 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		0		0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		-631,209,618			2.00
3.00	Total (sum of line 1 and line 2)		-631,209,618		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		-631,209,618		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-631,209,618		0	19.00

  

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/16/2013 12:00 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
<b>General Inpatient Routine Services</b>					
1.00	Hospital			0	1.00
2.00	SUBPROVIDER - IPF			0	2.00
3.00	SUBPROVIDER - IRF			0	3.00
4.00	SUBPROVIDER			0	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			0	7.00
8.00	NURSING FACILITY			0	8.00
9.00	OTHER LONG TERM CARE			0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	0		0	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT			0	12.00
13.00	BURN INTENSIVE CARE UNIT			0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)			0	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	0		0	17.00
18.00	Ancillary services	0	0	0	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY			0	22.00
23.00	AMBULANCE SERVICES			0	23.00
24.00	CMHC			0	24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)			0	25.00
26.00	HOSPICE			0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	0	0	0	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per wkst. A, column 3, line 200)		631,209,618		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)		631,209,618		43.00

## STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet G-3

Date/Time Prepared:  
11/16/2013 12:00 pm

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	0	1.00
2.00	Less contractual allowances and discounts on patients' accounts	0	2.00
3.00	Net patient revenues (line 1 minus line 2)	0	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	631,209,618	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-631,209,618	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	0	25.00
26.00	Total (line 5 plus line 25)	-631,209,618	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)	-631,209,618	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 140100

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet L  
Parts I-III  
Date/Time Prepared:  
11/16/2013 12:00 pm

		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		145,754	1.00
2.00	Capital DRG outlier payments		381,794	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		38.27	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		527,548	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00