

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).  
 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

FORM APPROVED  
 OMB NO. 0938-0050  
 Worksheet 5  
 Parts I-III  
 Date/Time Prepared:  
 10/1/2013 1:36 pm

Provider CCN: 144034

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

**PART I - COST REPORT STATUS**

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

**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 STREAMWOOD ( 144034 ) 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) *Dan Mullins*  
 Officer or Administrator of Provider(s)  
Division VP of Reimbursement  
 Title  
10-4-13  
 Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	0	0	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	0	0	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 144034

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
10/1/2013 1:35 pm

	1.00	2.00	3.00	4.00									
<b>Hospital and Hospital Health Care Complex Address:</b>													
1.00	Street: 1400 EAST IRVING PARK		PO Box:		Zip Code: 60107		County: COOK		1.00				
2.00	City: STREAMWOOD		State: IL		Zip Code: 60107		County: COOK		2.00				
	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)							
						V	XVIII	XIX					
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00					
<b>Hospital and Hospital-Based Component Identification:</b>													
3.00	Hospital		STREAMWOOD		144034	16974	4	05/01/1991	N	P	O	3.00	
4.00	Subprovider - IPF											4.00	
5.00	Subprovider - IRF											5.00	
6.00	Subprovider - (Other)											6.00	
7.00	Swing Beds - SNF											7.00	
8.00	Swing Beds - NF											8.00	
9.00	Hospital-Based SNF											9.00	
10.00	Hospital-Based NF											10.00	
11.00	Hospital-Based OLTC											11.00	
12.00	Hospital-Based HHA											12.00	
13.00	Separately Certified ASC											13.00	
14.00	Hospital-Based Hospice											14.00	
15.00	Hospital-Based Health Clinic - RHC											15.00	
16.00	Hospital-Based Health Clinic - FQHC											16.00	
17.00	Hospital-Based (CMHC) I											17.00	
18.00	Renal Dialysis											18.00	
19.00	Other											19.00	
						From:		To:					
						1.00		2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)						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.						3		N		23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days						
		1.00	2.00	3.00	4.00	5.00	6.00						
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible 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
		Urban/Rural S	Date of Geogr										
		1.00	2.00										
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.								1		26.00		
27.00	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: 144034	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 10/1/2013 1:35 pm
---	--	----------------------	---	---

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does 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	XVIII	XIX
		1.00	2.00	3.00

**Prospective Payment System (PPS)-Capital**

45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00

**Teaching Hospitals**

56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.				58.00
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>					
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	

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

64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00
-------	---	------	------	----------	-------

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 144034

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
10/1/2013 1:35 pm

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

		1.00	2.00	3.00	
<b>Inpatient Psychiatric Facility PPS</b>					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N	N	0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00
				1.00	
<b>Long Term Care Hospital PPS</b>					
80.00	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	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109.00
		1.00	2.00	3.00	
<b>Miscellaneous Cost Reporting Information</b>					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-i, §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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	118.01
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	399001	140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: UNIVERSAL HEALTH SERVICES	Contractor's Name: 399001		Contractor's Number: 399001	
142.00	Street: 367 SOUTH GULPH ROAD	PO Box:			
143.00	City: KING OF PRUSSIA	State: PA		Zip Code: 19406	
				1.00	
144.00	Are provider based physicians' costs included in worksheet A?		Y		144.00
145.00	If costs for renal services are claimed on worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		145.00
				1.00	2.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
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: 144034

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
10/1/2013 1:35 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
		<b>Name</b>	<b>County</b>	<b>State</b>	<b>Zip Code</b>	<b>CBSA</b>	<b>FTE/Campus</b>	
		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)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
<b>Financial Data and Reports</b>				
4.00	Column 1: were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		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.		N	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
<b>Bed Complement</b>				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
Description		Y/N	Date	Y/N
0		1.00	2.00	3.00
<b>PS&amp;R Data</b>				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/26/2012	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	
	0	1.00	2.00	3.00	
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
<b>Home Office Costs</b>					
36.00	were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			Y	12/31/2011
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN		SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	UHS, INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-312-5742		KEVIN.SMITH@UHSINC.COM	43.00

		Part B		
		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)	10/26/2012		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			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.		REIMBURSEMENT MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

		Title V	Title XIX	
		1.00	2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on w/s B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on w/s C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on w/s D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
<b>CRITICAL ACCESS HOSPITALS</b>				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
<b>RCE DISALLOWANCE</b>				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on w/s C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
<b>PASS THROUGH COST</b>				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 144034

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

worksheet S-3  
Part I  
Date/Time Prepared:  
10/1/2013 1:35 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	Title v
	Line Number	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	162	59,130	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)		162	59,130	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		162	59,130	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	46.00	0	0			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)		162				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)	26	29,094	39,664			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			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	26	29,094	39,664			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)	26	29,094	39,664	0.00	292.00	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			0	0.00	0.00	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	292.00	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 144034

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
10/1/2013 1:35 pm

Component	Full Time	Discharges			Total All Patients	
	Equivalents	Title V	Title XVIII	Title XIX		
	Nonpaid Workers	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	2	1,869	2,551	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	2	1,869	2,551	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	0.00				14	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	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

		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)	0.303807	1.00
<b>Medicaid (see instructions for each line)</b>			
2.00	Net revenue from Medicaid	0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	0	6.00
7.00	Medicaid cost (line 1 times line 6)	0	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>			
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
<b>Other state or local government indigent care program (see instructions for each line)</b>			
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
<b>Uncompensated care (see instructions for each line)</b>			
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00
		Uninsured patients	Insured patients
		1.00	2.00
			Total (col. 1 + col. 2)
			3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	0	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0
22.00	Partial payment by patients approved for charity care	0	0
23.00	Cost of charity care (line 21 minus line 22)	0	0
			1.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	0	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	0	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	0	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	0	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	0	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	0	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144034

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

Worksheet A

Date/Time Prepared:  
10/1/2013 1:35 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		1,544,974	1,544,974	161,790	1,706,764	1.00	
2.00	00200		346,619	346,619	91,731	438,350	2.00	
3.00	00300		0	0	0	0	3.00	
4.00	00400	291,784	2,369,331	2,661,115	0	2,661,115	4.00	
5.00	00500	2,025,826	2,615,275	4,641,101	-1,008,143	3,632,958	5.00	
7.00	00700	0	967,774	967,774	-6,352	961,422	7.00	
8.00	00800	0	151,009	151,009	0	151,009	8.00	
9.00	00900	0	495,641	495,641	0	495,641	9.00	
10.00	01000	324,491	351,646	676,137	0	676,137	10.00	
13.00	01300	915,158	1,685	916,843	0	916,843	13.00	
16.00	01600	209,946	126,866	336,812	0	336,812	16.00	
17.00	01700	0	0	0	0	0	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	6,940,859	2,404,449	9,345,308	0	9,345,308	30.00	
46.00	04600	0	0	0	0	0	46.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	0	0	0	0	0	54.00	
60.00	06000	0	63,213	63,213	0	63,213	60.00	
67.00	06700	0	0	0	0	0	67.00	
69.00	06900	0	0	0	0	0	69.00	
70.00	07000	0	0	0	0	0	70.00	
73.00	07300	0	566,782	566,782	0	566,782	73.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	913,473	435,288	1,348,761	435,162	1,783,923	90.00	
91.00	09100	0	0	0	0	0	91.00	
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00	SUBTOTALS (SUM OF LINES 1-117)		11,621,537	12,440,552	24,062,089	-325,812	23,736,277	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
192.00	19200	0	0	0	0	0	192.00	
194.00	07950	0	0	0	0	0	194.00	
194.01	07951	350,863	5,253	356,116	0	356,116	194.01	
194.02	07952	0	0	0	325,812	325,812	194.02	
194.03	07953	0	0	0	0	0	194.03	
200.00	TOTAL (SUM OF LINES 118-199)		11,972,400	12,445,805	24,418,205	0	24,418,205	200.00

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-58,691	1,648,073	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-26,708	411,642	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	98,376	2,759,491	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-135,234	3,497,724	5.00
7.00	00700	OPERATION OF PLANT	0	961,422	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	151,009	8.00
9.00	00900	HOUSEKEEPING	0	495,641	9.00
10.00	01000	DIETARY	-5,016	671,121	10.00
13.00	01300	NURSING ADMINISTRATION	0	916,843	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	336,812	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-2,421,189	6,924,119	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	63,213	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	566,782	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	-1,329,141	454,782	90.00
91.00	09100	EMERGENCY	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,877,603	19,858,674	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	EDUCATION	0	356,116	194.01
194.02	07952	MARKETING	0	325,812	194.02
194.03	07953	PHP MEALS	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	-3,877,603	20,540,602	200.00

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
13.00	NURSING ADMINISTRATION	01300		13.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	03000		30.00
46.00	OTHER LONG TERM CARE	04600		46.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	07950		194.00
194.01	EDUCATION	07951		194.01
194.02	MARKETING	07952		194.02
194.03	PHP MEALS	07953		194.03
200.00	TOTAL (SUM OF LINES 118-199)			200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>B - RENT LEASE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	161,790	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	91,731	2.00
3.00		0.00	0	0	3.00
TOTALS			0	253,521	
<b>C - COMMUNITY RELATIONS</b>					
1.00	MARKETING	194.02	274,363	51,449	1.00
TOTALS			274,363	51,449	
<b>D - TRANSPORTATION</b>					
1.00	CLINIC	90.00	26,797	190,784	1.00
TOTALS			26,797	190,784	
<b>E - PATIENT TRANSPORTATION</b>					
1.00	CLINIC	90.00	26,797	190,784	1.00
TOTALS			26,797	190,784	
500.00	Grand Total: Increases		327,957	686,538	500.00

RECLASSIFICATIONS

Provider CCN: 144034

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

worksheet A-6

Date/Time Prepared:  
10/1/2013 1:35 pm

		Decreases					
Cost Center		Line #	Salary	Other	wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
<b>B - RENT LEASE</b>							
1.00		0.00	0	0	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	247,169	10		2.00
3.00	OPERATION OF PLANT	7.00	0	6,352	0		3.00
	TOTALS		0	253,521			
<b>C - COMMUNITY RELATIONS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	274,363	51,449	0		1.00
	TOTALS		274,363	51,449			
<b>D - TRANSPORTATION</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	26,797	190,784	0		1.00
	TOTALS		26,797	190,784			
<b>E - PATIENT TRANSPORTATION</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	26,797	190,784	0		1.00
	TOTALS		26,797	190,784			
500.00	Grand Total: Decreases		327,957	686,538			500.00

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
<b>B -- RENT LEASE</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	0.00	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	ADMINISTRATIVE & GENERAL	5.00	2.00
3.00		0.00	0	OPERATION OF PLANT	7.00	3.00
	TOTALS		0	TOTALS		0
<b>C - COMMUNITY RELATIONS</b>						
1.00	MARKETING	194.02	274,363	ADMINISTRATIVE & GENERAL	5.00	274,363
	TOTALS		274,363	TOTALS		274,363
<b>D - TRANSPORTATION</b>						
1.00	CLINIC	90.00	26,797	ADMINISTRATIVE & GENERAL	5.00	26,797
	TOTALS		26,797	TOTALS		26,797
<b>E - PATIENT TRANSPORTATION</b>						
1.00	CLINIC	90.00	26,797	ADMINISTRATIVE & GENERAL	5.00	26,797
	TOTALS		26,797	TOTALS		26,797
500.00	Grand Total: Increases		327,957	Grand Total: Decreases		327,957

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144034

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
10/1/2013 1:35 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	2,240,512	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,349,308	0	0	0	3.00
4.00	Building Improvements	412,122	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	2,006,845	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,008,787	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24,008,787	0	0	0	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	2,240,512	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	19,349,308	0			3.00
4.00	Building Improvements	412,122	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	2,006,845	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	24,008,787	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	24,008,787	0			10.00

Provider CCN: 144034

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

Worksheet A-7  
 Part II  
 Date/Time Prepared:  
 10/1/2013 1:35 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation 9.00	Lease 10.00	Interest 11.00	Insurance (see instructions) 12.00	Taxes (see instructions) 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	825,312	0	0	60,600	659,062	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	313,868	0	0	32,751	0	2.00
3.00	Total (sum of lines 1-2)	1,139,180	0	0	93,351	659,062	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions) 14.00	Total (I) (sum of cols. 9 through 14) 15.00				
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,544,974				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	346,619				2.00
3.00	Total (sum of lines 1-2)	0	1,891,593				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144034

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
10/1/2013 1:35 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	766,621	161,790	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	287,160	91,731	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,053,781	253,521	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	0	60,600	659,062	0	1,648,073	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	32,751	0	0	411,642	2.00
3.00	Total (sum of lines 1-2)	0	93,351	659,062	0	2,059,715	3.00

Line #	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	Line #			
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	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)	A	-87,733	ADMINISTRATIVE & GENERAL	5.00	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	-3,691,527			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	565,672			0	12.00	
13.00	Laundry and linen service		0		0.00	0	13.00	
14.00	Cafeteria-employees and guests	A	-4,281	DIETARY	10.00	0	14.00	
15.00	Rental of quarters to employee and others		0		0.00	0	15.00	
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00	
17.00	Sale of drugs to other than patients		0		0.00	0	17.00	
18.00	Sale of medical records and abstracts		0		0.00	0	18.00	
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00	
20.00	Vending machines	A	-735	DIETARY	10.00	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	*** Cost Center Deleted ***	65.00		23.00	
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	66.00		24.00	
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00	
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	B	-58,691	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00	
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	B	-26,708	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	OCCUPATIONAL THERAPY	67.00		30.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00	
33.00	PHYSICIAN COSTS	B	-23,020	ADULTS & PEDIATRICS	30.00	0	33.00	
34.00	PHYSICIAN COSTS	B	-35,950	CLINIC	90.00	0	34.00	
35.00	PHYSICIAN COSTS	B	-199,279	EMPLOYEE BENEFITS	4.00	0	35.00	
36.00	MISC REVENUE	A	-27,171	ADMINISTRATIVE & GENERAL	5.00	0	36.00	

			Expense Classification on Worksheet A To/From which the Amount is to be Adjusted				
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.		
	1.00	2.00	3.00	4.00	5.00		
37.00	PT TRANSPORTATION	B	-9,870	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	PT TRANSPORTATION	B	205	ADULTS & PEDIATRICS	30.00	0	38.00
39.00			0		0.00	0	39.00
40.00	PT TRANSPORTATION	B	-38	CLINIC	90.00	0	40.00
41.00	REBATES OFFSET FOR INFO ONLY	A	87,733	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00			0		0.00	0	42.00
43.00			0		0.00	0	43.00
44.00	DONATIONS	B	-11,260	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	PHYSICIAN BILLING	B	-83,083	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00	PHYSICIAN RECRUITING	B	-1,692	ADMINISTRATIVE & GENERAL	5.00	0	46.00
47.00	LOBBYING	B	-9,855	ADMINISTRATIVE & GENERAL	5.00	0	47.00
48.00	BAD DEBT	B	-260,320	ADMINISTRATIVE & GENERAL	5.00	0	48.00
49.00			0		0.00	0	49.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-3,877,603				50.00

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

Provider CCN: 144034

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

worksheet A-8-1

Date/Time Prepared: 10/1/2013 1:35 pm

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	1,090,642	803,100	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	-252,676	2.00
3.00	4.00	EMPLOYEE BENEFITS	184,203	-113,452	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	0	272,201	4.00
5.00	0		1,274,845	709,173	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	B	0.00	UNIVERSAL HEALT	100.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 144034

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

worksheet A-8-1

Date/Time Prepared:  
10/1/2013 1:35 pm

	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</b>			
<b>HOME OFFICE COSTS:</b>			
1.00	287,542	0	1.00
2.00	252,676	0	2.00
3.00	297,655	0	3.00
4.00	-272,201	0	4.00
5.00	565,672		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>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	HOSPITAL		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144034

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

worksheet A-8-2

Date/Time Prepared:  
10/1/2013 1:35 pm

	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	2,398,374	2,398,374	0	0	0	1.00
2.00	90.00	AGGREGATE-CLINIC	1,293,153	1,293,153	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			3,691,527	3,691,527	0	0	0	200.00
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	90.00	AGGREGATE-CLINIC	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			0	0	0	0	0	200.00
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	2,398,374		1.00
2.00	90.00	AGGREGATE-CLINIC	0	0	0	1,293,153		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	0	0	3,691,527		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144034

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

Worksheet B  
Part I  
Date/Time Prepared:  
10/1/2013 1:35 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP				
		1.00	2.00	4.00			
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,648,073	1,648,073				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	411,642		411,642			2.00
4.00 00400	EMPLOYEE BENEFITS	2,759,491	0	0	2,759,491		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,497,724	363,105	90,693	401,113	4,352,635	5.00
7.00 00700	OPERATION OF PLANT	961,422	117,568	29,365	0	1,108,355	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	151,009	24,205	6,046	0	181,260	8.00
9.00 00900	HOUSEKEEPING	495,641	11,559	2,887	0	510,087	9.00
10.00 01000	DIETARY	671,121	96,082	23,999	76,659	867,861	10.00
13.00 01300	NURSING ADMINISTRATION	916,843	14,014	3,500	216,202	1,150,559	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	336,812	13,453	3,360	49,599	403,224	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	6,924,119	928,088	231,811	1,639,746	9,723,764	30.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 06000	LABORATORY	63,213	0	0	0	63,213	60.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	566,782	10,419	2,602	0	579,803	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	454,782	59,021	14,742	228,465	757,010	90.00
91.00 09100	EMERGENCY	0	0	0	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	19,858,674	1,637,514	409,005	2,611,784	19,697,771	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07951	EDUCATION	356,116	9,629	2,405	82,890	451,040	194.01
194.02 07952	MARKETING	325,812	930	232	64,817	391,791	194.02
194.03 07953	PHP MEALS	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	TOTAL (sum lines 118-201)	20,540,602	1,648,073	411,642	2,759,491	20,540,602	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144034

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

worksheet B  
Part I  
Date/Time Prepared:  
10/1/2013 1:35 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.00	00500	4,352,635					5.00	
7.00	00700	298,016	1,406,371				7.00	
8.00	00800	48,737	29,159	259,156			8.00	
9.00	00900	137,153	13,925	0	661,165		9.00	
10.00	01000	233,351	115,750	0	56,136	1,273,098	10.00	
13.00	01300	309,363	16,883	0	8,188	0	13.00	
16.00	01600	108,419	16,207	0	7,860	0	16.00	
17.00	01700	0	0	0	0	0	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	2,614,534	1,118,074	259,156	542,242	1,248,278	30.00	
46.00	04600	0	0	0	0	0	46.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	0	0	0	0	0	54.00	
60.00	06000	16,997	0	0	0	0	60.00	
67.00	06700	0	0	0	0	0	67.00	
69.00	06900	0	0	0	0	0	69.00	
70.00	07000	0	0	0	0	0	70.00	
73.00	07300	155,898	12,551	0	6,087	0	73.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	203,546	71,102	0	34,483	0	90.00	
91.00	09100	0	0	0	0	0	91.00	
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00	SUBTOTALS (SUM OF LINES 1-117)		4,126,014	1,393,651	259,156	654,996	1,248,278	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
192.00	19200	0	0	0	0	0	192.00	
194.00	07950	0	0	0	0	0	194.00	
194.01	07951	121,276	11,600	0	5,626	0	194.01	
194.02	07952	105,345	1,120	0	543	0	194.02	
194.03	07953	0	0	0	0	24,820	194.03	
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers						201.00	
202.00	TOTAL (sum lines 118-201)		4,352,635	1,406,371	259,156	661,165	1,273,098	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144034

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

Worksheet B  
Part I  
Date/Time Prepared:  
10/1/2013 1:35 pm

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	16.00	17.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
13.00	01300	1,484,993					13.00
16.00	01600	0	535,710				16.00
17.00	01700	0	0	0			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,484,993	535,710	0	17,526,751	0	30.00
46.00	04600	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	80,210	0	60.00
67.00	06700	0	0	0	0	0	67.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	0	0	0	754,339	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	1,066,141	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		1,484,993	535,710	0	19,427,441	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	589,542	0	194.01
194.02	07952	0	0	0	498,799	0	194.02
194.03	07953	0	0	0	24,820	0	194.03
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,484,993	535,710	0	20,540,602	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144034

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

Worksheet B  
Part I  
Date/Time Prepared:  
10/1/2013 1:35 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
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
46.00	04600	OTHER LONG TERM CARE	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	EDUCATION	194.01
194.02	07952	MARKETING	194.02
194.03	07953	PHP MEALS	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	P	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
13.00	NURSING ADMINISTRATION	P	PATIENT DAYS	13.00
16.00	MEDICAL RECORDS & LIBRARY	P	PATIENT DAYS	16.00
17.00	SOCIAL SERVICE	P	PATIENT DAYS	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144034

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

Worksheet B  
Part II  
Date/Time Prepared:  
10/1/2013 1:35 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS
		BLDG & FIXT	MVBLE EQUIP		
		0	1.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	26,828	363,105	90,693	5.00
7.00 00700	OPERATION OF PLANT	0	117,568	29,365	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	24,205	6,046	8.00
9.00 00900	HOUSEKEEPING	0	11,559	2,887	9.00
10.00 01000	DIETARY	0	96,082	23,999	10.00
13.00 01300	NURSING ADMINISTRATION	0	14,014	3,500	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	13,453	3,360	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 03000	ADULTS & PEDIATRICS	0	928,088	231,811	30.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	60.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	67.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	10,419	2,602	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000	CLINIC	0	59,021	14,742	90.00
91.00 09100	EMERGENCY	0	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00	SUBTOTALS (SUM OF LINES 1-117)	26,828	1,637,514	409,005	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
194.01 07951	EDUCATION	0	9,629	2,405	194.01
194.02 07952	MARKETING	0	930	232	194.02
194.03 07953	PHP MEALS	0	0	0	194.03
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	TOTAL (sum lines 118-201)	26,828	1,648,073	411,642	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144034

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

worksheet B  
Part II  
Date/Time Prepared:  
10/1/2013 1:35 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	480,626				5.00
7.00	00700	OPERATION OF PLANT	32,907	179,840			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,382	3,729	39,362		8.00
9.00	00900	HOUSEKEEPING	15,144	1,781	0	31,371	9.00
10.00	01000	DIETARY	25,767	14,802	0	2,664	10.00
13.00	01300	NURSING ADMINISTRATION	34,160	2,159	0	388	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,972	2,072	0	373	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	288,704	142,974	39,362	25,728	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	1,877	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,214	1,605	0	289	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	22,476	9,092	0	1,636	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	455,603	178,214	39,362	31,078	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	EDUCATION	13,391	1,483	0	267	194.01
194.02	07952	MARKETING	11,632	143	0	26	194.02
194.03	07953	PHP MEALS	0	0	0	0	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	480,626	179,840	39,362	31,371	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144034

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

Worksheet B  
Part II  
Date/Time Prepared:  
10/1/2013 1:35 pm

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	16.00	17.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
13.00	01300	54,221					13.00
16.00	01600	0	31,230				16.00
17.00	01700	0	0	0			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	54,221	31,230	0	1,902,248	0	30.00
46.00	04600	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	1,877	0	60.00
67.00	06700	0	0	0	0	0	67.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	0	0	0	32,129	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	106,967	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		54,221	31,230	0	2,043,221	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	27,175	0	194.01
194.02	07952	0	0	0	12,963	0	194.02
194.03	07953	0	0	0	3,184	0	194.03
200.00					0		200.00
201.00		0	0	0	0	0	201.00
202.00		54,221	31,230	0	2,086,543	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144034

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

Worksheet B  
Part II  
Date/Time Prepared:  
10/1/2013 1:35 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
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
46.00	04600	OTHER LONG TERM CARE	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	EDUCATION	194.01
194.02	07952	MARKETING	194.02
194.03	07953	PHP MEALS	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	93,963				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		93,963			2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	11,680,616		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	20,702	20,702	1,697,869	-4,352,635	16,187,967 5.00
7.00 00700	OPERATION OF PLANT	6,703	6,703	0	0	1,108,355 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,380	1,380	0	0	181,260 8.00
9.00 00900	HOUSEKEEPING	659	659	0	0	510,087 9.00
10.00 01000	DIETARY	5,478	5,478	324,491	0	867,861 10.00
13.00 01300	NURSING ADMINISTRATION	799	799	915,158	0	1,150,559 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	767	767	209,946	0	403,224 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	52,914	52,914	6,940,859	0	9,723,764 30.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	0 46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
60.00 06000	LABORATORY	0	0	0	0	63,213 60.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	594	594	0	0	579,803 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	3,365	3,365	967,067	0	757,010 90.00
91.00 09100	EMERGENCY	0	0	0	0	0 91.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	93,361	93,361	11,055,390	-4,352,635	15,345,136 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
194.01 07951	EDUCATION	549	549	350,863	0	451,040 194.01
194.02 07952	MARKETING	53	53	274,363	0	391,791 194.02
194.03 07953	PHP MEALS	0	0	0	0	0 194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per wkst. B, Part I)	1,648,073	411,642	2,759,491		4,352,635 202.00
203.00	Unit cost multiplier (wkst. B, Part I)	17.539595	4.380895	0.236245		0.268881 203.00
204.00	Cost to be allocated (per wkst. B, Part II)			0		480,626 204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.000000		0.029690 205.00

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (PATIENT DAYS)		
		7.00	8.00	9.00	10.00	13.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.00	00500						5.00	
7.00	00700	66,558					7.00	
8.00	00800	1,380	39,664				8.00	
9.00	00900	659	0	64,519			9.00	
10.00	01000	5,478	0	5,478	121,358		10.00	
13.00	01300	799	0	799	0	39,664	13.00	
16.00	01600	767	0	767	0	0	16.00	
17.00	01700	0	0	0	0	0	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	52,914	39,664	52,914	118,992	39,664	30.00	
46.00	04600	0	0	0	0	0	46.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	0	0	0	0	0	54.00	
60.00	06000	0	0	0	0	0	60.00	
67.00	06700	0	0	0	0	0	67.00	
69.00	06900	0	0	0	0	0	69.00	
70.00	07000	0	0	0	0	0	70.00	
73.00	07300	594	0	594	0	0	73.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	3,365	0	3,365	0	0	90.00	
91.00	09100	0	0	0	0	0	91.00	
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00	SUBTOTALS (SUM OF LINES 1-117)		65,956	39,664	63,917	118,992	39,664	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
192.00	19200	0	0	0	0	0	192.00	
194.00	07950	0	0	0	0	0	194.00	
194.01	07951	549	0	549	0	0	194.01	
194.02	07952	53	0	53	0	0	194.02	
194.03	07953	0	0	0	2,366	0	194.03	
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers							201.00
202.00	Cost to be allocated (per wkst. B, Part I)		1,406,371	259,156	661,165	1,273,098	1,484,993	202.00
203.00	Unit cost multiplier (wkst. B, Part I)		21.130007	6.533784	10.247601	10.490433	37.439315	203.00
204.00	Cost to be allocated (per wkst. B, Part II)		179,840	39,362	31,371	163,314	54,221	204.00
205.00	Unit cost multiplier (wkst. B, Part II)		2.702004	0.992386	0.486229	1.345721	1.367008	205.00

Cost Center Description		MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	
		16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	39,664	16.00
17.00	01700	SOCIAL SERVICE	0 39,664	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	39,664	30.00
46.00	04600	OTHER LONG TERM CARE	0 0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0 0	54.00
60.00	06000	LABORATORY	0 0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0 0	67.00
69.00	06900	ELECTROCARDIOLOGY	0 0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0 0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0 0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0 0	90.00
91.00	09100	EMERGENCY	0 0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,664 39,664	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0 0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0 0	194.00
194.01	07951	EDUCATION	0 0	194.01
194.02	07952	MARKETING	0 0	194.02
194.03	07953	PHP MEALS	0 0	194.03
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)	535,710 0	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	13.506202 0.000000	203.00
204.00		Cost to be allocated (per wkst. B, Part II)	31,230 0	204.00
205.00		Unit cost multiplier (wkst. B, Part II)	0.787364 0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

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

Worksheet C  
Part I  
Date/Time Prepared:  
10/1/2013 1:35 pm

Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		PPS	
			Total Costs	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	17,526,751		17,526,751	0	17,526,751	30.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00
60.00	06000	LABORATORY	80,210		80,210	0	80,210	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	754,339		754,339	0	754,339	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	1,066,141		1,066,141	0	1,066,141	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
200.00		Subtotal (see instructions)	19,427,441	0	19,427,441	0	19,427,441	200.00
201.00		Less Observation Beds	0		0	0	0	201.00
202.00		Total (see instructions)	19,427,441	0	19,427,441	0	19,427,441	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

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

Worksheet C  
Part I  
Date/Time Prepared:  
10/1/2013 1:35 pm

Cost Center Description		Title XVIII			Hospital	PPS		
		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
6.00	7.00	8.00	9.00	10.00				
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	55,416,150		55,416,150			30.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	06000	LABORATORY	403,358	117	403,475	0.198798	0.000000	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,391,812	0	2,391,812	0.315384	0.000000	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	5,735,128	5,735,128	0.185897	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
200.00		Subtotal (see instructions)	58,211,320	5,735,245	63,946,565			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	58,211,320	5,735,245	63,946,565			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

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

Worksheet C  
Part I  
Date/Time Prepared:  
10/1/2013 1:35 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
46.00	04600 OTHER LONG TERM CARE				46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.198798			60.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.315384			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.185897			90.00
91.00	09100 EMERGENCY	0.000000			91.00
200.00	Subtotal (see instructions)				200.00
201.00	Less observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

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

Worksheet C  
Part I  
Date/Time Prepared:  
10/1/2013 1:35 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	17,526,751		17,526,751	0	0	30.00
46.00	04600 OTHER LONG TERM CARE	0		0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400 RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00
60.00	06000 LABORATORY	80,210		80,210	0	0	60.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	754,339		754,339	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	1,066,141		1,066,141	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
200.00	Subtotal (see instructions)	19,427,441	0	19,427,441	0	0	200.00
201.00	Less Observation Beds	0		0			201.00
202.00	Total (see instructions)	19,427,441	0	19,427,441	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

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

Worksheet C  
Part I  
Date/Time Prepared:  
10/1/2013 1:35 pm

Cost Center Description	Title XIX			Hospital	Cost	
	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
6.00	7.00	8.00	9.00	10.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	55,416,150			30.00
46.00	04600	OTHER LONG TERM CARE	0			46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000	LABORATORY	403,358	117	403,475	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,391,812	0	2,391,812	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	5,735,128	5,735,128	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
200.00		Subtotal (see instructions)	58,211,320	5,735,245	63,946,565	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	58,211,320	5,735,245	63,946,565	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

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

Worksheet C  
Part I  
Date/Time Prepared:  
10/1/2013 1:35 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
46.00	04600 OTHER LONG TERM CARE				46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 144034

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

Worksheet D  
Part I  
Date/Time Prepared:  
10/1/2013 1:36 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Capital Related Cost (from wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	1,902,248	0	1,902,248	39,664	47.96	30.00
200.00	Total (lines 30-199)	1,902,248		1,902,248	39,664		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	26	1,247				
200.00	Total (lines 30-199)	26	1,247				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 144034

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

Worksheet D  
Part II  
Date/Time Prepared:  
10/1/2013 1:35 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>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0	54.00
60.00	06000	LABORATORY	1,877	403,475	0.004652	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,129	2,391,812	0.013433	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	106,967	5,735,128	0.018651	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0	91.00
200.00		Total (Lines 50-199)	140,973	8,530,415		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

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

Worksheet D  
Part III  
Date/Time Prepared:  
10/1/2013 1:36 pm

Cost Center Description			Title XVIII			Hospital	PPS	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)		
			1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	39,664	0.00	26	0	0	30.00
200.00		Total (lines 30-199)	39,664		26	0	0	200.00
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
			12.00	13.00				
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	0				
200.00		Total (lines 30-199)	0	0				

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

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

Worksheet D  
Part IV  
Date/Time Prepared:  
10/1/2013 1:35 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>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<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
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

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

Worksheet D  
Part IV  
Date/Time Prepared:  
10/1/2013 1:35 pm

		Title XVIII		Hospital		PPS		
Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	403,475	0.000000	0.000000	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,391,812	0.000000	0.000000	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	5,735,128	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00
200.00		Total (lines 50-199)	0	8,530,415			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

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

Worksheet D  
Part IV  
Date/Time Prepared:  
10/1/2013 1:35 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School		
		11.00	12.00	13.00	21.00	22.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
200.00		Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS  
 Provider CCN: 144034  
 Period: From 07/01/2012 To 06/30/2013  
 Worksheet D Part IV  
 Date/Time Prepared: 10/1/2013 1:35 pm

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 144034

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

worksheet D  
Part I  
Date/Time Prepared:  
10/1/2013 1:35 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	Per Diem (col. 3 / col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	1,902,248	0	1,902,248	39,664	47.96	30.00
200.00	Total (lines 30-199)	1,902,248		1,902,248	39,664		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	29,094	1,395,348				
200.00	Total (lines 30-199)	29,094	1,395,348				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 144034

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

worksheet D  
Part II  
Date/Time Prepared:  
10/1/2013 1:35 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0	0	54.00
60.00	06000	LABORATORY	1,877	403,475	0.004652	291,716	1,357	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,129	2,391,812	0.013433	1,827,636	24,551	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	106,967	5,735,128	0.018651	0	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
200.00		Total (lines 50-199)	140,973	8,530,415		2,119,352	25,908	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

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

Worksheet D  
Part III  
Date/Time Prepared:  
10/1/2013 1:35 pm

Cost Center Description		Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
200.00		Total (lines 30-199)	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)	PSA Adj. Nursing School	
		6.00	7.00	8.00	9.00	11.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	39,664	0.00	29,094	0	30.00
200.00		Total (lines 30-199)	39,664		29,094	0	200.00
Cost Center Description		PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
		12.00	13.00				
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	0			30.00
200.00		Total (lines 30-199)	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

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

Worksheet D  
Part IV  
Date/Time Prepared:  
10/1/2013 1:35 pm

Cost Center Description		Title XIX			Hospital	Cost	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

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

Worksheet D  
Part IV  
Date/Time Prepared:  
10/1/2013 1:35 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C; Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0.000000	0	54.00
60.00	06000 LABORATORY	0	403,475	0.000000	0.000000	291,716	60.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,391,812	0.000000	0.000000	1,827,636	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	5,735,128	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0.000000	0	91.00
200.00	Total (lines 50-199)	0	8,530,415			2,119,352	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

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

Worksheet D  
Part IV  
Date/Time Prepared:  
10/1/2013 1:35 pm

Cost Center Description			Title XIX			Hospital		
			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
<b>ANCILLARY SERVICE COST CENTERS</b>			11.00	12.00	13.00	21.00	22.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

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

Worksheet D  
Part IV  
Date/Time Prepared:  
10/1/2013 1:35 pm

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN:144034

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

worksheet D-1

Date/Time Prepared:  
10/1/2013 1:35 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)			39,664 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			39,664 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)			39,664 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			26 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)			17,526,751 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)			17,526,751 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)			55,416,150 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			55,416,150 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.316275 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			1,397.14 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)			17,526,751 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)			441.88 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			11,489 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)			11,489 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144034

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

Worksheet D-1

Date/Time Prepared:  
10/1/2013 1:35 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						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
<b>Cost Center Description</b>						
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1.00	0 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,489	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)					1,247	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,247	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					10,242	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)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144034

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

Worksheet D-1

Date/Time Prepared:  
10/1/2013 1:35 pm

Cost Center Description	Cost	Title XVIII		Hospital	PPS	
		Routine Cost (from line 27)	column 1 = column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
90.00 Capital-related cost	1,902,248	17,526,751	0.108534	0	0	90.00
91.00 Nursing school cost	0	17,526,751	0.000000	0	0	91.00
92.00 Allied health cost	0	17,526,751	0.000000	0	0	92.00
93.00 All other Medical Education	0	17,526,751	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144034

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

worksheet D-1

Date/Time Prepared:  
10/1/2013 1:35 pm

Title XIX		Hospital	Cost	
Cost Center Description			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		39,664	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		39,664	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)		39,664	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)		29,094	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)		17,526,751	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)		17,526,751	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		55,416,150	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		55,416,150	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.316275	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,397.14	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)		17,526,751	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)		441.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		12,856,057	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		12,856,057	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN:144034		Period: From 07/01/2012 To 06/30/2013		worksheet D-1		
		Title XIX		Hospital		Date/Time Prepared: 10/1/2013 1:35 pm		
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost			
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)			
	1.00	2.00	3.00	4.00	5.00			
42.00	<b>NURSERY (title V &amp; XIX only)</b>							42.00
	<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00	INTENSIVE CARE UNIT							43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
	<b>Cost Center Description</b>							
								1.00
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					634,400		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					13,490,457		49.00
	<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0		53.00
	<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00	Program discharges					0		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)					0		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					0		71.00
72.00	Program routine service cost (line 9 x line 71)					0		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					0		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)					0		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0		76.00
77.00	Program capital-related costs (line 9 x line 76)					0		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0		80.00
81.00	Inpatient routine service cost per diem limitation					0		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0		82.00
83.00	Reasonable inpatient routine service costs (see instructions)					0		83.00
84.00	Program inpatient ancillary services (see instructions)					0		84.00
85.00	Utilization review - physician compensation (see instructions)					0		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					0		86.00
	<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00	Total observation bed days (see instructions)					0		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144034

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

worksheet D-1  
Date/Time Prepared:  
10/1/2013 1:35 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 144034	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 10/1/2013 1:36 pm
--	----------------------	---	---

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	PPS
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		33,800		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000 LABORATORY	0.198798	0	0	60.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.315384	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.185897	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
200.00	Total (sum of lines 50-94 and 96-98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		0	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 144034

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

Worksheet D-3

Date/Time Prepared:  
10/1/2013 1:35 pm

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		37,809,763		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000 LABORATORY	0.198798	291,716	57,993	60.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.315384	1,827,636	576,407	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.185897	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
200.00	Total (sum of lines 50-94 and 96-98)		2,119,352	634,400	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		2,119,352		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144034	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part II Date/Time Prepared: 10/1/2013 1:35 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			0 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			108.668493 9.00
10.00	Medical Education Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$ .			0.000000 10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			0 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition			0 14.00
15.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)			0 15.00
16.00	Subtotal (see instructions)			0 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			0 18.00
19.00	Deductibles			0 19.00
20.00	Subtotal (line 18 minus line 19)			0 20.00
21.00	Coinsurance			0 21.00
22.00	Subtotal (line 20 minus line 21)			0 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			0 26.00
27.00	Direct graduate medical education payments (from worksheet E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			0 31.00
32.00	Interim payments			0 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)			0 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0.00 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 144034

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

Worksheet E-3  
Part VII  
Date/Time Prepared:  
10/1/2013 1:35 pm

		Title XIX		Hospital		Cost	
				Inpatient	Outpatient		
				1.00	2.00		
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>							
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>							
1.00	Inpatient hospital/SNF/NF services			13,490,457			1.00
2.00	Medical and other services				0		2.00
3.00	Organ acquisition (certified transplant centers only)			0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)			13,490,457		0	4.00
5.00	Inpatient primary payer payments			1,125,202			5.00
6.00	Outpatient primary payer payments					0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)			12,365,255		0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>							
<b>Reasonable Charges</b>							
8.00	Routine service charges			37,809,763			8.00
9.00	Ancillary service charges			2,119,352		0	9.00
10.00	Organ acquisition charges, net of revenue			0			10.00
11.00	Incentive from target amount computation			0			11.00
12.00	Total reasonable charges (sum of lines 8 through 11)			39,929,115		0	12.00
<b>CUSTOMARY CHARGES</b>							
13.00	Amount actually collected from patients liable for payment for services on a charge basis			0		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)			0.000000		0.000000	15.00
16.00	Total customary charges (see instructions)			39,929,115		0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			26,438,658		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			0		0	18.00
19.00	Interns and Residents (see instructions)			0		0	19.00
20.00	Cost of Teaching Physicians (see instructions)			0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)			13,490,457		0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>							
22.00	Other than outlier payments			0		0	22.00
23.00	Outlier payments			0		0	23.00
24.00	Program capital payments			0			24.00
25.00	Capital exception payments (see instructions)			0			25.00
26.00	Routine and Ancillary service other pass through costs			0		0	26.00
27.00	Subtotal (sum of lines 22 through 26)			0		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)			0		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)			13,490,457		0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>							
30.00	Excess of reasonable cost (from line 18)			0		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			12,365,255		0	31.00
32.00	Deductibles			0		0	32.00
33.00	Coinsurance			0		0	33.00
34.00	Allowable bad debts (see instructions)			0		0	34.00
35.00	Utilization review			0			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			12,365,255		0	36.00
37.00	ELIMINATE SETTLEMENT			9,114,595		0	37.00
38.00	Subtotal (line 36 ± line 37)			21,479,850		0	38.00
39.00	Direct graduate medical education payments (from wkst. E-4)			0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)			21,479,850		0	40.00
41.00	Interim payments			21,479,850		0	41.00
42.00	Balance due provider/program (line 40 minus 41)			0		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2			0		0	43.00

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

Provider CCN: 144034

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

Worksheet G

Date/Time Prepared:  
10/1/2013 1:35 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	-68,436	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	7,260,167	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	74,997	0	0	0	7.00
8.00	Prepaid expenses	54,734	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)	7,321,462	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	2,240,512	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	19,894,084	0	0	0	15.00
16.00	Accumulated depreciation	-2,129,704	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	2,157,412	0	0	0	23.00
24.00	Accumulated depreciation	-781,170	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)	21,381,134	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	61,729,719	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	61,729,719	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	90,432,315	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	595,046	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,871,527	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	65,220,126	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)	68,686,699	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)	68,686,699	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	21,745,616	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	21,745,616	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	90,432,315	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 144034

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

Worksheet G-1  
Date/Time Prepared:  
10/1/2013 1:35 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		10,829,393		0	
2.00	Net income (loss) (from wkst. G-3, line 29)		10,916,224			
3.00	Total (sum of line 1 and line 2)		21,745,617		0	
4.00	Additions (credit adjustments) (specify)	0		0		0
5.00		0		0		0
6.00		0		0		0
7.00		0		0		0
8.00		0		0		0
9.00		0		0		0
10.00	Total additions (sum of line 4-9)		0		0	
11.00	Subtotal (line 3 plus line 10)		21,745,617		0	
12.00		0		0		0
13.00		0		0		0
14.00		0		0		0
15.00		0		0		0
16.00		0		0		0
17.00		0		0		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)		21,745,617		0	
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00			0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 144034

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
10/1/2013 1:35 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	55,416,150		55,416,150	1.00
2.00 SUBPROVIDER - IPF				2.00
3.00 SUBPROVIDER - IRF				3.00
4.00 SUBPROVIDER				4.00
5.00 Swing bed - SNF	0		0	5.00
6.00 Swing bed - NF	0		0	6.00
7.00 SKILLED NURSING FACILITY				7.00
8.00 NURSING FACILITY				8.00
9.00 OTHER LONG TERM CARE	0		0	9.00
10.00 Total general inpatient care services (sum of lines 1-9)	55,416,150		55,416,150	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>				
11.00 INTENSIVE CARE UNIT				11.00
12.00 CORONARY CARE UNIT				12.00
13.00 BURN INTENSIVE CARE UNIT				13.00
14.00 SURGICAL INTENSIVE CARE UNIT				14.00
15.00 OTHER SPECIAL CARE (SPECIFY)				15.00
16.00 Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00 Total inpatient routine care services (sum of lines 10 and 16)	55,416,150		55,416,150	17.00
18.00 Ancillary services	3,262,740	0	3,262,740	18.00
19.00 Outpatient services	0	5,735,245	5,735,245	19.00
20.00 RURAL HEALTH CLINIC	0	0	0	20.00
21.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULANCE SERVICES				23.00
24.00 CMHC				24.00
25.00 AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00 HOSPICE				26.00
27.00	0	0	0	27.00
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	58,678,890	5,735,245	64,414,135	28.00
<b>PART II - OPERATING EXPENSES</b>				
29.00 Operating expenses (per wkst. A, column 3, line 200)		24,418,205		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)		24,418,205		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 144034

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

Worksheet G-3

Date/Time Prepared:  
10/1/2013 1:36 pm

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)		
2.00	Less contractual allowances and discounts on patients' accounts	64,414,135	1.00
3.00	Net patient revenues (line 1 minus line 2)	29,186,262	2.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	35,227,873	3.00
5.00	Net income from service to patients (line 3 minus line 4)	24,418,205	4.00
	<b>OTHER INCOME</b>	10,809,668	5.00
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	4,281	14.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	15.00
17.00	Revenue from sale of drugs to other than patients	0	16.00
18.00	Revenue from sale of medical records and abstracts	0	17.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	18.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	19.00
21.00	Rental of vending machines	735	20.00
22.00	Rental of hospital space	0	21.00
23.00	Governmental appropriations	0	22.00
24.00	MISC REVENUE	0	23.00
25.00	Total other income (sum of lines 6-24)	101,540	24.00
26.00	Total (line 5 plus line 25)	106,556	25.00
27.00	OTHER EXPENSES (SPECIFY)	10,916,224	26.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	27.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	0	28.00
		10,916,224	29.00