

**ST. VINCENT CLAY HOSPITAL
BRAZIL, INDIANA**

**PROVIDER NO. 15-1309 and 15-Z309
AND AIM NO. 200448850**

**HOSPITAL STATEMENTS OF REIMBURSABLE COSTS
(MEDICARE AND MEDICAID PROGRAMS)**

JUNE 30, 2012

ST. VINCENT CLAY HOSPITAL

PROVIDER NOS. 15-1309 and 15-Z309
AND AIM NO. 200448850

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Accountants' Disclaimer

Hospital Statements of Reimbursable Costs



Bradley Associates
Healthcare Advisors and CPAs

Board of Directors
St. Vincent Clay Hospital
Brazil, Indiana

We have compiled the Hospital Statement of Reimbursable Costs (Title XVIII and XIX) of St. Vincent Clay Hospital for the year ended June 30, 2012 in the accompanying prescribed form in accordance with Statements on Standards for Accounting Review Services issued by the American Institute of Certified Public Accountants.

Our compilation was limited to presenting in the form prescribed by the Centers for Medicare and Medicaid Services, information that is the representation of management. We have not audited or reviewed the report referred to above and, accordingly, do not express an opinion or any other form of assurance on it.

The report is presented in accordance with the requirements of the Centers for Medicare and Medicaid Services, which differ from generally accepted accounting principles. Accordingly, this report is not designed for those who are not informed about such differences.

This report is intended to be filed with the Centers for Medicare and Medicaid Services and should not be used for any other purposes.

Bradley Associates

November 29, 2012

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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151309	Period: From 07/01/2011 To 06/30/2012	Worksheet 5 Parts I-III Date/Time Prepared: 11/29/2012 1:42 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 11/29/2012	Time: 1:42 pm
	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. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT CLAY HOSPITAL for the cost reporting period beginning 07/01/2011 and ending 06/30/2012 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 11/29/2012 Time: 1:42 pm
hz2S3KvqM.TNb73yUDiUYi2JHYFbj0
YU:sB0j1Ia0Ib525x92Vh43PzdTv:x
Mj7D0K3GD702dGvr
PI: Date: 11/29/2012 Time: 1:42 pm
0jPMkDwz0iojk9hNlJ4ZF7mi3d9:L0
PwmDR0:hBnYg:TSaxuKzczshwUrmRH
XYHGBUey:y0tp:6l

(Signed) _____
Officer or Administrator of Provider(s)

Title

Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	183,898	-121,844	0	1.00
2.00	Subprovider - IPF	0	0	0	0	2.00
3.00	Subprovider - IRF	0	0	0	0	3.00
4.00	SUBPROVIDER I	0	0	0	0	4.00
5.00	Swing bed - SNF	0	118,007	0	0	5.00
6.00	Swing bed - NF	0	0	0	0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0	0	7.00
8.00	NURSING FACILITY	0	0	0	0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	9.00
10.00	RURAL HEALTH CLINIC I	0	0	0	0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	11.00
12.00	CMHC I	0	0	0	0	12.00
200.00	Total	0	301,905	-121,844	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: 151309 Period: From 07/01/2011 To 06/30/2012 Worksheet S-2 Part I Date/Time Prepared: 11/29/2012 12:04 pm

		1.00	2.00	3.00	4.00				
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1206 EAST NATIONAL AVENUE	PO Box:						1.00	
2.00	City: BRAZIL	State: IN	Zip Code: 47834	County: CLAY				2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
							V	XVIII	
							XIX		
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	
		8.00							
Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST. VINCENT CLAY HOSPITAL	151309	45460	1	08/08/2001	N	O	
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF	ST. VINCENT CLAY SWING BEDS	152309	45460		08/08/2001	N	O	
8.00	Swing Beds - NF						N	N	
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) 1								
18.00	Renal Dialysis								
19.00	Other								
						From:	To:		
						1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2011	06/30/2012	20.00
21.00	Type of Control (see instructions)						1		21.00
Inpatient PPS Information									
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						N	N	22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.						2	N	23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00	
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.						2		26.00
27.00	For the Standard Geographic Classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.						0		37.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151309	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/29/2012 12:04 pm		
		Beginning: 1.00	Ending: 2.00			
		V 1.00	XVIII 2.00	XIX 3.00		
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
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 the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete worksheet L, Part III and L-1, Parts I through III	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
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 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00		61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)		0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)		0.00			62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.		0.00	0.00	0.000000	64.00
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151309

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

Worksheet S-2
Part I
Date/Time Prepared:
11/29/2012 12:04 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	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
				1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151309	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/29/2012 12:04 pm
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		1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: column 1: Did the facility have a teaching program in the most recent cost reporting period filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: column 1: Did the facility have 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			
Long Term Care Hospital PPS					
80.00	Are you a long term care hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. LTCHs can only exist as independent/freestanding facilities. An independent or freestanding facility may exist as an unrelated hospital within a hospital, it must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22(e.)			N	80.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	86.00
		V	XIX		
		1.00	2.00		
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		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.			Y	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	N	Y	N
		1.00	2.00	3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151309	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/29/2012 12:04 pm
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		1.00	2.00	3.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self insurance paid in column 3.	19,249	0	0	118.01
		1.00	2.00		
118.02	Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPs calculation on worksheet E, Part B, line 8.	N	N		120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		15H046	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: ST. VINCENT HEALTH	Contractor's Name: WPS		Contractor's Number: 08101	141.00
142.00	Street: 10330 N. MERIDIAN ST.	PO Box:			142.00
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46290	143.00
		1.00			
144.00	Are provider based physicians' costs included in worksheet A?		Y		144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		145.00
		1.00	2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N			147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N			148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N			149.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151309		Period: From 07/01/2011 To 06/30/2012		Worksheet S-2 Part I Date/Time Prepared: 11/29/2012 12:04 pm	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00169.00

		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00	
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00	
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00	
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	09/15/2011	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
		Part A			
		Description	Y/N	Date	
		0	1.00	2.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/08/2012		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			20.00

		Part A		
Description		Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	2.00	21.00
		1.00	2.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	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
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	GARY	MARKER	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3232	GAMARKER@STVINCENT.ORG	43.00

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/08/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR OF REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151309

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

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2012 12:04 pm

Cost Center Description		Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	
		1.00	2.00	3.00	4.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,150	40,824.00	1.00
2.00	HMO					2.00
3.00	HMO IPF					3.00
4.00	HMO IRF					4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					5.00
6.00	Hospital Adults & Peds. Swing Bed NF					6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	40,824.00	7.00
8.00	INTENSIVE CARE UNIT					8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)		25	9,150	40,824.00	14.00
15.00	CAH visits					15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00	Total (sum of lines 14-26)		25			27.00
28.00	Observation Bed Days					28.00
29.00	Ambulance Trips					29.00
30.00	Employee discount days (see instruction)					30.00
31.00	Employee discount days - IRF					31.00
32.00	Labor & delivery days (see instructions)					32.00
33.00	LTCH non-covered days					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151309

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

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2012 12:04 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,298	118	1,701		1.00
2.00 HMO		83	125			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	941	0	941		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		22	130		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,239	140	2,772		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	2,239	140	2,772		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	679		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				24		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: 151309

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

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2012 12:04 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	390	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	141.78	0.00	0	390	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	141.78	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	35	549		1.00
2.00 HMO				2.00
3.00 HMO IPF				3.00
4.00 HMO IRF				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF				5.00
6.00 Hospital Adults & Peds. Swing Bed NF				6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00 INTENSIVE CARE UNIT				8.00
9.00 CORONARY CARE UNIT				9.00
10.00 BURN INTENSIVE CARE UNIT				10.00
11.00 SURGICAL INTENSIVE CARE UNIT				11.00
12.00 OTHER SPECIAL CARE (SPECIFY)				12.00
13.00 NURSERY				13.00
14.00 Total (see instructions)	35	549		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 151309

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

Worksheet S-10

Date/Time Prepared:
11/29/2012 12:04 pm

		1.00	
Uncompensated and indigent care cost computation			
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)	0.352350	1.00
Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid	2,592,674	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	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	10,393,564	6.00
7.00	Medicaid cost (line 1 times line 6)	3,662,172	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)	1,069,498	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)			
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
Other state or local government indigent care program (see instructions for each line)			
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
Uncompensated care (see instructions for each line)			
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	35,436	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,069,498	19.00
		Uninsured patients	Insured patients
		1.00	2.00
		3.00	Total (col. 1 + col. 2)
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	4,545,299	2,705
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,601,536	953
22.00	Partial payment by patients approved for charity care	0	0
23.00	Cost of charity care (line 21 minus line 22)	1,601,536	953
		1.00	3.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,945,959	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	334,364	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	1,611,595	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	567,845	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	2,170,334	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,239,832	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151309

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

Worksheet A

Date/Time Prepared:
11/29/2012 12:04 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		507,599	507,599	-221,427	286,172	1.00
2.00	00200		1,287,297	1,287,297	185,043	1,472,340	2.00
2.01	00201		361,962	361,962	0	361,962	2.01
4.00	00400	129,707	1,995,984	2,125,691	0	2,125,691	4.00
5.00	00500	1,941,460	2,509,435	4,450,895	36,384	4,487,279	5.00
7.00	00700	299,540	464,460	764,000	0	764,000	7.00
8.00	00800	0	54,244	54,244	0	54,244	8.00
9.00	00900	147,611	109,435	257,046	0	257,046	9.00
10.00	01000	172,484	153,268	325,752	-170,075	155,677	10.00
11.00	01100	0	0	0	170,075	170,075	11.00
13.00	01300	223,565	41,225	264,790	23,544	288,334	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	1,157,361	1,157,361	0	1,157,361	15.00
16.00	01600	193,964	12,945	206,909	0	206,909	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,078,553	103,675	1,182,228	0	1,182,228	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	520,121	275,194	795,315	-96,732	698,583	50.00
53.00	05300	328,308	2,715	331,023	0	331,023	53.00
54.00	05400	677,463	328,280	1,005,743	-43,853	961,890	54.00
60.00	06000	351,778	718,579	1,070,357	0	1,070,357	60.00
65.00	06500	176,444	53,612	230,056	-37,520	192,536	65.00
66.00	06600	0	622,159	622,159	0	622,159	66.00
68.00	06800	0	9,973	9,973	0	9,973	68.00
69.00	06900	99,222	16,182	115,404	0	115,404	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	504,487	504,487	198,521	703,008	71.00
72.00	07200	0	282,075	282,075	-62,940	219,135	72.00
73.00	07300	0	7,669	7,669	43,853	51,522	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	783,671	1,172,165	1,955,836	-1,329	1,954,507	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		7,123,891	12,751,980	19,875,871	23,544	19,899,415	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	10,364	10,364	0	10,364	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	-9,580	1,277	-8,303	0	-8,303	193.01
193.02	19302	47,089	800	47,889	-23,544	24,345	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	0	331	331	0	331	193.04
193.05	19305	0	0	0	0	0	193.05
200.00		7,161,400	12,764,752	19,926,152	0	19,926,152	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151309

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

Worksheet A
Date/Time Prepared:
11/29/2012 12:04 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	161,891	448,063	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-176,993	1,295,347	2.00
2.01	00201	CAP REL COSTS-MOB	0	361,962	2.01
4.00	00400	EMPLOYEE BENEFITS	174,539	2,300,230	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	153,622	4,640,901	5.00
7.00	00700	OPERATION OF PLANT	-1,712	762,288	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	54,244	8.00
9.00	00900	HOUSEKEEPING	0	257,046	9.00
10.00	01000	DIETARY	5,502	161,179	10.00
11.00	01100	CAFETERIA	-32,315	137,760	11.00
13.00	01300	NURSING ADMINISTRATION	0	288,334	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	2,903	1,160,264	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,506	201,403	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,575	1,185,803	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,806	702,389	50.00
53.00	05300	ANESTHESIOLOGY	-331,023	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,154	975,044	54.00
60.00	06000	LABORATORY	4,019	1,074,376	60.00
65.00	06500	RESPIRATORY THERAPY	96	192,632	65.00
66.00	06600	PHYSICAL THERAPY	-180	621,979	66.00
68.00	06800	SPEECH PATHOLOGY	0	9,973	68.00
69.00	06900	ELECTROCARDIOLOGY	1,732	117,136	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,308	709,316	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	219,135	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-839	50,683	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	1,348	1,955,855	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-16,073	19,883,342	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,364	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	8,303	0	193.01
193.02	19302	PUBLIC RELATIONS	282,996	307,341	193.02
193.03	19303	FOUNDATION	0	0	193.03
193.04	19304	MISSION SERVICES	0	331	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	0	193.05
200.00		TOTAL (SUM OF LINES 118-199)	275,226	20,201,378	200.00

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - NURSING EDUCATION					
1.00	NURSING ADMINISTRATION	13.00	23,544	0	1.00
	TOTALS		23,544	0	
B - INTEREST					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	36,384	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	88,705	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	174,893	3.00
	TOTALS		0	299,982	
C - CAFETERIA					
1.00	CAFETERIA	11.00	90,054	80,021	1.00
	TOTALS		90,054	80,021	
D - PROPERTY INSURANCE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	10,150	1.00
	TOTALS		0	10,150	
E - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	135,581	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	43,853	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	179,434	
F - IMPLANTABLE DEVICES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	62,940	1.00
	TOTALS		0	62,940	
500.00	Grand Total: Increases		113,598	632,527	500.00

		Decreases				
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - NURSING EDUCATION						
1.00	PUBLIC RELATIONS	193.02	23,544	0	0	1.00
	TOTALS		23,544	0		
B - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	263,598	11	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	36,384	11	2.00
3.00		0.00	0	0	11	3.00
	TOTALS		0	299,982		
C - CAFETERIA						
1.00	DIETARY	10.00	90,054	80,021	0	1.00
	TOTALS		90,054	80,021		
D - PROPERTY INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	10,150	11	1.00
	TOTALS		0	10,150		
E - MEDICAL SUPPLIES						
1.00	EMERGENCY	91.00	0	1,329	0	1.00
2.00	OPERATING ROOM	50.00	0	96,732	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	43,853	0	3.00
4.00	RESPIRATORY THERAPY	65.00	0	37,520	0	4.00
	TOTALS		0	179,434		
F - IMPLANTABLE DEVICES						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	62,940	0	1.00
	TOTALS		0	62,940		
500.00	Grand Total: Decreases		113,598	632,527		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151309

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/29/2012 12:04 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,500	0	0	0	1.00
2.00	Land Improvements	317,947	0	0	5,460	2.00
3.00	Buildings and Fixtures	9,000,671	0	0	13,115	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	9,301,545	251,077	0	251,077	5.00
6.00	Movable Equipment	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,622,663	251,077	0	251,077	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	18,622,663	251,077	0	251,077	10.00
SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	192,319	0	299,982	15,298	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	379,180	709,295	0	1,247	2.00
2.01	CAP REL COSTS-MOB	32,890	329,072	0	0	2.01
3.00	Total (sum of lines 1-2)	604,389	1,038,367	299,982	16,545	3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	2.00
2.01	CAP REL COSTS-MOB	0	0	0	0.000000	2.01
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,500	0			1.00
2.00	Land Improvements	312,487	0			2.00
3.00	Buildings and Fixtures	8,987,556	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	9,552,622	0			5.00
6.00	Movable Equipment	0	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	18,855,165	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	18,855,165	0			10.00
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	507,599			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	197,575	1,287,297			2.00
2.01	CAP REL COSTS-MOB	0	361,962			2.01
3.00	Total (sum of lines 1-2)	197,575	2,156,858			3.00
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	354,210	0
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	202,187	709,295
2.01	CAP REL COSTS-MOB	0	0	0	32,890	329,072
3.00	Total (sum of lines 1-2)	0	0	0	589,287	1,038,367

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151309

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/29/2012 12:04 pm

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	78,555	15,298	0	0	448,063	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	185,043	1,247	0	197,575	1,295,347	2.00
2.01	CAP REL COSTS-MOB	0	0	0	0	361,962	2.01
3.00	Total (sum of lines 1-2)	263,598	16,545	0	197,575	2,105,372	3.00

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From Which the Amount is to be Adjusted	
				Cost Center	Line #
				1.00	2.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-78,600	CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-154,969	CAP REL COSTS-MVBLE EQUIP	2.00 2.00
2.01	Investment income - CAP REL COSTS-MOB (chapter 2)		0	CAP REL COSTS-MOB	2.01 2.01
3.00	Investment income - other (chapter 2)	B	-32,240	ADMINISTRATIVE & GENERAL	5.00 3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00	Refunds and rebates of expenses (chapter 8)	A	110	ADMINISTRATIVE & GENERAL	5.00 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-9,000	ADMINISTRATIVE & GENERAL	5.00 7.00
8.00	Television and radio service (chapter 21)	A	-2,272	OPERATION OF PLANT	7.00 8.00
9.00	Parking lot (chapter 21)		0		0.00 9.00
10.00	Provider-based physician adjustment	A-8-2	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00 11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,047,070		12.00
13.00	Laundry and linen service		0		0.00 13.00
14.00	Cafeteria-employees and guests	B	-32,315	CAFETERIA	11.00 14.00
15.00	Rental of quarters to employee and others		0		0.00 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00	Sale of drugs to other than patients	B	-5,816	DRUGS CHARGED TO PATIENTS	73.00 17.00
18.00	Sale of medical records and abstracts	B	-5,506	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00	Vending machines		0		0.00 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00 23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00 24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00 25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00 27.00
27.01	Depreciation - CAP REL COSTS-MOB		0	CAP REL COSTS-MOB	2.01 27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00 28.00
29.00	Physicians' assistant		0		0.00 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00 30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00 31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00 32.00
33.00	GAIN ON SALE OF PP&E OFFSET	B	-2,100	CAP REL COSTS-MVBLE EQUIP	2.00 33.00
33.01	MISC. INCOME - EMPLOYEE BENEFITS	B	-1,315	EMPLOYEE BENEFITS	4.00 33.01
33.02	MISC. INCOME - A&G	B	-8,891	ADMINISTRATIVE & GENERAL	5.00 33.02
33.03	MISC. INCOME - RADIOLOGY	B	-4,804	RADIOLOGY-DIAGNOSTIC	54.00 33.03
33.04	MISC. INCOME - PT	B	-180	PHYSICAL THERAPY	66.00 33.04
33.05	MISC. INCOME - MEDICAL SUPPLIES	B	-33	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00 33.05
33.06	MGMT. FEE REV. OFFSET - A&G	B	-1,140	ADMINISTRATIVE & GENERAL	5.00 33.06
33.07	MGMT. FEE REV. OFFSET - SURGERY	B	-1,664	OPERATING ROOM	50.00 33.07
33.08	LOBBYING	A	-578	ADMINISTRATIVE & GENERAL	5.00 33.08
33.09	GIFTS/DONATIONS	A	-2,085	ADMINISTRATIVE & GENERAL	5.00 33.09
33.10	NON-REIMBURSABLE ANESTHESIOLOGY	A	-331,023	ANESTHESIOLOGY	53.00 33.10
33.11	NON-REIMBURSABLE ALCOHOL	A	-1,380	ADMINISTRATIVE & GENERAL	5.00 33.11
33.12	OTHER PURCHASE REBATES - MAINTENANCE	A	560	OPERATION OF PLANT	7.00 33.12
33.13	OTHER PURCHASE REBATES - DIETARY	A	5,502	DIETARY	10.00 33.13
33.14	OTHER PURCHASE REBATES - PHARMACY	A	2,866	PHARMACY	15.00 33.14
33.15	OTHER PURCHASE REBATES - A&P	A	1,022	ADULTS & PEDIATRICS	30.00 33.15
33.16	OTHER PURCHASE REBATES - SURGERY	A	476	OPERATING ROOM	50.00 33.16
33.17	OTHER PURCHASE REBATES - RADIOLOGY	A	65	RADIOLOGY-DIAGNOSTIC	54.00 33.17

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Provider CCN: 151309

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

Worksheet A-8

Date/Time Prepared:
11/29/2012 12:04 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted		
			Cost Center	Line #	
	1.00	2.00	3.00	4.00	
33.18 OTHER PURCHASE REBATES - RT	A	14	RESPIRATORY THERAPY	65.00	33.18
33.19 OTHER PURCHASE REBATES - EKG	A	72	ELECTROCARDIOLOGY	69.00	33.19
33.20 OTHER PURCHASE REBATES - SUPPLIES	A	6,341	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	33.20
33.21 OTHER PURCHASE REBATES - IV THERAPY	A	4,977	DRUGS CHARGED TO PATIENTS	73.00	33.21
33.22 INCENTIVE ADJUSTMENT - WAGES	A	-29,025	ADMINISTRATIVE & GENERAL	5.00	33.22
33.23 INCENTIVE ADJUSTMENT - FICA	A	-2,220	EMPLOYEE BENEFITS	4.00	33.23
33.24 CLAY CITY MEDICAL CLINIC	A	8,303	CLAY CITY MEDICAL CLINIC	193.01	33.24
33.25 PHYSICIAN RECRUITMENT	A	-94,996	ADMINISTRATIVE & GENERAL	5.00	33.25
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		275,226			50.00

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	9	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	9	2.00
2.01	Investment income - CAP REL COSTS-MOB (chapter 2)	0	2.01
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	0	27.00
27.01	Depreciation - CAP REL COSTS-MOB	0	27.01
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	GAIN ON SALE OF PP&E OFFSET	9	33.00
33.01	MISC. INCOME - EMPLOYEE BENEFITS	0	33.01
33.02	MISC. INCOME - A&G	0	33.02
33.03	MISC. INCOME - RADIOLOGY	0	33.03
33.04	MISC. INCOME - PT	0	33.04
33.05	MISC. INCOME - MEDICAL SUPPLIES	0	33.05
33.06	MGMT. FEE REV. OFFSET - A&G	0	33.06
33.07	MGMT. FEE REV. OFFSET - SURGERY	0	33.07
33.08	LOBBYING	0	33.08
33.09	GIFTS/DONATIONS	0	33.09
33.10	NON-REIMBURSABLE ANESTHESIOLOGY	0	33.10
33.11	NON-REIMBURSABLE ALCOHOL	0	33.11
33.12	OTHER PURCHASE REBATES - MAINTENANCE	0	33.12
33.13	OTHER PURCHASE REBATES - DIETARY	0	33.13
33.14	OTHER PURCHASE REBATES - PHARMACY	0	33.14
33.15	OTHER PURCHASE REBATES - A&P	0	33.15
33.16	OTHER PURCHASE REBATES - SURGERY	0	33.16
33.17	OTHER PURCHASE REBATES - RADIOLOGY	0	33.17
33.18	OTHER PURCHASE REBATES - RT	0	33.18
33.19	OTHER PURCHASE REBATES - EKG	0	33.19
33.20	OTHER PURCHASE REBATES - SUPPLIES	0	33.20
33.21	OTHER PURCHASE REBATES - IV THERAPY	0	33.21
33.22	INCENTIVE ADJUSTMENT - WAGES	0	33.22
33.23	INCENTIVE ADJUSTMENT - FICA	0	33.23
33.24	CLAY CITY MEDICAL CLINIC	0	33.24

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Provider CCN: 151309

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

Worksheet A-8

Date/Time Prepared:
 11/29/2012 12:04 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
33.25	PHYSICIAN RECRUITMENT	0	33.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 151309

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

Worksheet A-8-1

Date/Time Prepared: 11/29/2012 12:04 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2.00
3.00	4.00	EMPLOYEE BENEFITS	ST. VINCENT HOSPITAL - IN	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	ST. VINCENT HOSPITAL - IN	4.00
4.01	7.00	OPERATION OF PLANT	ST. VINCENT HOSPITAL - IN	4.01
4.02	9.00	HOUSEKEEPING	ST. VINCENT HOSPITAL - IN	4.02
4.03	13.00	NURSING ADMINISTRATION	ST. VINCENT HOSPITAL - IN	4.03
4.04	14.00	CENTRAL SERVICES & SUPPLY	ST. VINCENT HOSPITAL - IN	4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY	ST. VINCENT HOSPITAL - IN	4.05
4.06	30.00	ADULTS & PEDIATRICS	ST. VINCENT HOSPITAL - IN	4.06
4.07	53.00	ANESTHESIOLOGY	ST. VINCENT HOSPITAL - IN	4.07
4.08	54.00	RADIOLOGY-DIAGNOSTIC	ST. VINCENT HOSPITAL - IN	4.08
4.09	60.00	LABORATORY	ST. VINCENT HOSPITAL - IN	4.09
4.10	91.00	EMERGENCY	ST. VINCENT HOSPITAL - IN	4.10
4.11	193.01	CLAY CITY MEDICAL CLINIC	ST. VINCENT HOSPITAL - IN	4.11
4.12	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION CHARGEBACK	4.12
4.13	2.00	CAP REL COSTS-MVBLE EQUIP	ASCENSION CHARGEBACK	4.13
4.14	4.00	EMPLOYEE BENEFITS	ASCENSION CHARGEBACK	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	ASCENSION CHARGEBACK	4.15
4.16	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	4.16
4.17	2.00	CAP REL COSTS-MVBLE EQUIP	ASCENSION INTEREST	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	4.18
4.19	4.00	EMPLOYEE BENEFITS	PENSION ADJUSTMENT	4.19
4.20	4.00	EMPLOYEE BENEFITS	SELF-INSURANCE	4.20
4.21	193.02	PUBLIC RELATIONS	MARKETING	4.21
4.22	30.00	ADULTS & PEDIATRICS	ASCENSION MAINTENANCE	4.22
4.23	50.00	OPERATING ROOM	ASCENSION MAINTENANCE	4.23
4.24	5.00	ADMINISTRATIVE & GENERAL	ASCENSION MAINTENANCE	4.24
4.25	60.00	LABORATORY	ASCENSION MAINTENANCE	4.25
4.26	69.00	ELECTROCARDIOLOGY	ASCENSION MAINTENANCE	4.26
4.27	54.00	RADIOLOGY-DIAGNOSTIC	ASCENSION MAINTENANCE	4.27
4.28	15.00	PHARMACY	ASCENSION MAINTENANCE	4.28
4.29	65.00	RESPIRATORY THERAPY	ASCENSION MAINTENANCE	4.29
4.30	91.00	EMERGENCY	ASCENSION MAINTENANCE	4.30
4.31	4.00	EMPLOYEE BENEFITS	HOME OFFICE	4.31
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.			5.00

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

	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	G	ST. VINCENT HEA	100.00	6.00
7.00	B	ST. VINCENT HOS	100.00	7.00
8.00	G	ASCENSION	100.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:			100.00
		HOME OFFICE		

(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: 151309

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

Worksheet A-8-1

Date/Time Prepared: 11/29/2012 12:04 pm

	Amount of Allowable Cost	Amount Included in wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	250,596	0	250,596	9	1.00
2.00	1,445,650	1,108,882	336,768	0	2.00
3.00	224,546	224,546	0	0	3.00
4.00	921,418	921,418	0	0	4.00
4.01	33,132	33,132	0	0	4.01
4.02	210	210	0	0	4.02
4.03	15	15	0	0	4.03
4.04	1,428	1,428	0	0	4.04
4.05	21,105	21,105	0	0	4.05
4.06	250	250	0	0	4.06
4.07	2,715	2,715	0	0	4.07
4.08	10,268	10,268	0	0	4.08
4.09	4,589	4,589	0	0	4.09
4.10	650	650	0	0	4.10
4.11	299	299	0	0	4.11
4.12	315,280	315,280	0	9	4.12
4.13	1,247	1,247	0	9	4.13
4.14	61,500	61,500	0	0	4.14
4.15	29,539	29,539	0	0	4.15
4.16	78,600	88,705	-10,105	9	4.16
4.17	154,969	174,893	-19,924	9	4.17
4.18	32,240	36,384	-4,144	0	4.18
4.19	174,992	174,992	0	0	4.19
4.20	1,063,250	819,859	243,391	0	4.20
4.21	282,996	0	282,996	0	4.21
4.22	25,784	23,231	2,553	0	4.22
4.23	50,441	45,447	4,994	0	4.23
4.24	2,254	2,031	223	0	4.24
4.25	40,598	36,579	4,019	0	4.25
4.26	16,769	15,109	1,660	0	4.26
4.27	180,751	162,858	17,893	0	4.27
4.28	365	328	37	0	4.28
4.29	829	747	82	0	4.29
4.30	13,621	12,273	1,348	0	4.30
4.31	0	65,317	-65,317	0	4.31
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	5,442,896	4,395,826	1,047,070	5.00

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

Related Organization(s) and/or Home Office			
Name	Percentage of Ownership	Type of Business	
4.00	5.00	6.00	

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

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

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

6.00	ST. VINCENT HEA	100.00	ADMINISTRATION	6.00
7.00	ST. VINCENT HOS	100.00	HOSPITAL	7.00
8.00	ASCENSION	100.00	ADMINISTRATION	8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

Provider CCN: 151309

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

Worksheet A-8-1

Date/Time Prepared:
11/29/2012 12:04 pm

	Related Organization(s) and/or Home Office		
	Name	Percentage of Ownership	Type of Business
	4.00	5.00	6.00

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

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- 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: 151309

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

Worksheet A-8-2

Date/Time Prepared:
11/29/2012 12:04 pm

	Wkst: A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	91.00	EMERGENCY	893,031	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	1,600	0	2.00
3.00	0.00		0	0	3.00
4.00	0.00		0	0	4.00
5.00	0.00		0	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			894,631	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151309

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

Worksheet A-8-2

Date/Time Prepared:
11/29/2012 12:04 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	893,031	0	0	0	0	1.00
2.00	1,600	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	894,631					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151309

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

Worksheet A-8-2

Date/Time Prepared:
11/29/2012 12:04 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151309

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

Worksheet A-8-2

Date/Time Prepared:
11/29/2012 12:04 pm

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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151309		Period: From 07/01/2011 To 06/30/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/29/2012 12:04 pm	
		Physical Therapy		Cost			
				1.00			
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					539	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					4	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	1,577.00	4,622.00	3,751.00	4,520.00	0.00	9.00
10.00	AHSEA (see instructions)	83.91	72.97	54.72	48.64	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.49	36.49	27.36			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					132,326	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					337,267	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					205,255	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					674,848	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					219,853	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					894,701	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					894,701	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					19,668	24.00
25.00	Assistants (line 4 times column 3, line 11)					109	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					19,777	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					2,987	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					22,764	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					22,764	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151309	Period: From 07/01/2011 To 06/30/2012	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/29/2012 12:04 pm
		Physical Therapy	Cost

					1.00	
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46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	

PART V - OVERTIME COMPUTATION

47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00

CALCULATION OF LIMIT

50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00

DETERMINATION OF OVERTIME ALLOWANCE

52.00	Adjusted hourly salary equivalency amount (see instructions)	72.97	54.72	48.64	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

						1.00	
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Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57.00	Salary equivalency amount (from line 23)		894,701	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		22,764	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		917,465	63.00
64.00	Total cost of outside supplier services (from your records)		620,053	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00

LINE 33 CALCULATION

100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		19,777	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		2,987	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		22,764	100.02

LINE 34 CALCULATION

101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		2,987	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		2,987	101.02

LINE 35 CALCULATION

102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151309

Period:
From 07/01/2011
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	Cost Center Description	Net Expenses for Cost Allocation (From Wkst. A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	
			BLDG & FIXT	MVBLE EQUIP	MOB		
			1.00	2.00	2.01		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	448,063	448,063			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,295,347		1,295,347		2.00
2.01	00201	CAP REL COSTS-MOB	361,962		0	361,962	2.01
4.00	00400	EMPLOYEE BENEFITS	2,300,230	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,640,901	162,784	460,602	18,044	2,300,230
7.00	00700	OPERATION OF PLANT	762,288	91,951	260,176	0	665,250
8.00	00800	LAUNDRY & LINEN SERVICE	54,244	9,611	27,194	0	102,639
9.00	00900	HOUSEKEEPING	257,046	5,330	15,080	0	0
10.00	01000	DIETARY	161,179	11,838	33,496	0	50,580
11.00	01100	CAFETERIA	137,760	6,715	19,000	0	28,245
13.00	01300	NURSING ADMINISTRATION	288,334	10,491	29,684	0	30,857
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	84,673
15.00	01500	PHARMACY	1,160,264	5,259	14,880	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	201,403	46,625	131,925	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,185,803	30,266	85,639	0	66,463
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	702,389	12,425	35,156	0	178,222
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	975,044	8,616	24,380	0	232,136
60.00	06000	LABORATORY	1,074,376	7,046	19,938	14,420	120,538
65.00	06500	RESPIRATORY THERAPY	192,632	8,497	24,042	0	60,459
66.00	06600	PHYSICAL THERAPY	621,979	0	0	42,572	0
68.00	06800	SPEECH PATHOLOGY	9,973	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	117,136	0	0	0	33,999
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	709,316	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	219,135	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	50,683	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,955,855	24,931	70,543	0	268,529
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,883,342	442,385	1,251,735	75,036	2,292,162
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,152	3,259	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,364	0	0	286,926	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	CLAY CITY MEDICAL CLINIC	0	0	27,547	0	0
193.02	19302	PUBLIC RELATIONS	307,341	272	769	0	8,068
193.03	19303	FOUNDATION	0	0	0	0	0
193.04	19304	MISSION SERVICES	331	0	0	0	0
193.05	19305	OTHER NON-REIMBURSABLE	0	4,254	12,037	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		TOTAL (sum lines 118-201)	20,201,378	448,063	1,295,347	361,962	2,300,230

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151309

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

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Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500	5,947,581	5,947,581				5.00
7.00	00700	1,217,054	507,832	1,724,886			7.00
8.00	00800	91,049	37,991	77,307	206,347		8.00
9.00	00900	328,036	136,877	42,871	6,796	514,580	9.00
10.00	01000	234,758	97,956	95,225	2,545	0	10.00
11.00	01100	194,332	81,088	54,015	0	0	11.00
13.00	01300	413,182	172,406	84,387	0	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	1,180,403	492,538	42,303	0	0	15.00
16.00	01600	446,416	186,273	375,042	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,671,280	697,363	243,459	64,055	262,391	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	928,192	387,300	99,945	32,655	132,630	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	1,240,176	517,480	69,310	26,640	39,853	54.00
60.00	06000	1,236,318	515,870	99,639	0	39,853	60.00
65.00	06500	285,630	119,183	68,349	8,528	0	65.00
66.00	06600	664,551	277,293	126,821	0	0	66.00
68.00	06800	9,973	4,161	0	0	0	68.00
69.00	06900	151,135	63,063	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	709,316	295,971	0	0	0	71.00
72.00	07200	219,135	91,437	0	0	0	72.00
73.00	07300	50,683	21,148	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	2,319,858	967,989	200,545	65,128	39,853	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		19,539,058	5,671,219	1,679,218	206,347	514,580	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	4,411	1,841	9,265	0	0	190.00
192.00	19200	297,290	124,048	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	27,547	11,494	0	0	0	193.01
193.02	19302	316,450	132,043	2,185	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	331	138	0	0	0	193.04
193.05	19305	16,291	6,798	34,218	0	0	193.05
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		20,201,378	5,947,581	1,724,886	206,347	514,580	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151309

Period:
From 07/01/2011
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
2.01	00201						2.01
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	430,484					10.00
11.00	01100	0	329,435				11.00
13.00	01300	0	15,974	685,949			13.00
14.00	01400	0	0	0	0		14.00
15.00	01500	0	0	0	0	1,715,244	15.00
16.00	01600	0	25,113	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	430,484	83,190	307,789	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	46,515	172,101	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	48,585	0	0	0	54.00
60.00	06000	0	30,346	0	0	0	60.00
65.00	06500	0	15,427	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	6,600	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	1,715,244	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	55,693	206,059	0	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		430,484	327,443	685,949	0	1,715,244	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	0	1,992	0	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	0	0	0	0	0	193.04
193.05	19305	0	0	0	0	0	193.05
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		430,484	329,435	685,949	0	1,715,244	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151309

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

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Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MOB				2.01
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
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,032,844			16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,996	3,803,007	0	3,803,007
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	115,140	1,914,478	0	1,914,478
53.00	05300	ANESTHESIOLOGY	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	276,344	2,218,388	0	2,218,388
60.00	06000	LABORATORY	166,740	2,088,766	0	2,088,766
65.00	06500	RESPIRATORY THERAPY	12,538	509,655	0	509,655
66.00	06600	PHYSICAL THERAPY	56,238	1,124,903	0	1,124,903
68.00	06800	SPEECH PATHOLOGY	203	14,337	0	14,337
69.00	06900	ELECTROCARDIOLOGY	32,637	253,435	0	253,435
70.00	07000	ELECTROENCEPHALOGRAPHY	607	607	0	607
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,308	1,047,595	0	1,047,595
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,805	324,377	0	324,377
73.00	07300	DRUGS CHARGED TO PATIENTS	92,399	1,879,474	0	1,879,474
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	180,889	4,036,014	0	4,036,014
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0	
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,032,844	19,215,036	0	19,215,036
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,517	0	15,517
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	421,338	0	421,338
193.00	19300	NONPAID WORKERS	0	0	0	0
193.01	19301	CLAY CITY MEDICAL CLINIC	0	39,041	0	39,041
193.02	19302	PUBLIC RELATIONS	0	452,670	0	452,670
193.03	19303	FOUNDATION	0	0	0	0
193.04	19304	MISSION SERVICES	0	469	0	469
193.05	19305	OTHER NON-REIMBURSABLE	0	57,307	0	57,307
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,032,844	20,201,378	0	20,201,378

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151309

Period:
From 07/01/2011
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal
		BLDG & FIXT	MVBLE EQUIP	MOB	
		1.00	2.00	2.01	
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
2.01 00201	CAP REL COSTS-MOB				2.01
4.00 00400	EMPLOYEE BENEFITS	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	162,784	460,602	5.00
7.00 00700	OPERATION OF PLANT	0	91,951	260,176	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	9,611	27,194	8.00
9.00 00900	HOUSEKEEPING	0	5,330	15,080	9.00
10.00 01000	DIETARY	0	11,838	33,496	10.00
11.00 01100	CAFETERIA	0	6,715	19,000	11.00
13.00 01300	NURSING ADMINISTRATION	0	10,491	29,684	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	14.00
15.00 01500	PHARMACY	0	5,259	14,880	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	46,625	131,925	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	30,266	85,639	30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	12,425	35,156	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	8,616	24,380	54.00
60.00 06000	LABORATORY	0	7,046	19,938	60.00
65.00 06500	RESPIRATORY THERAPY	0	8,497	24,042	65.00
66.00 06600	PHYSICAL THERAPY	0	0	42,572	66.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00 09100	EMERGENCY	0	24,931	70,543	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	442,385	1,251,735	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,152	3,259	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	286,926	192.00
193.00 19300	NONPAID WORKERS	0	0	0	193.00
193.01 19301	CLAY CITY MEDICAL CLINIC	0	0	27,547	193.01
193.02 19302	PUBLIC RELATIONS	0	272	769	193.02
193.03 19303	FOUNDATION	0	0	0	193.03
193.04 19304	MISSION SERVICES	0	0	0	193.04
193.05 19305	OTHER NON-REIMBURSABLE	0	4,254	12,037	193.05
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	TOTAL (sum lines 118-201)	0	448,063	1,295,347	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151309

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

Worksheet B
Part II
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Cost Center Description		EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4.00	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
2.01	00201						2.01
4.00	00400	0					4.00
5.00	00500	0	641,430				5.00
7.00	00700	0	54,769	406,896			7.00
8.00	00800	0	4,097	18,237	59,139		8.00
9.00	00900	0	14,762	10,113	1,948	47,233	9.00
10.00	01000	0	10,564	22,463	729	0	10.00
11.00	01100	0	8,745	12,742	0	0	11.00
13.00	01300	0	18,594	19,907	0	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	53,119	9,979	0	0	15.00
16.00	01600	0	20,089	88,471	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	75,209	57,431	18,358	24,085	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	41,770	23,577	9,359	12,174	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	55,809	16,350	7,635	3,658	54.00
60.00	06000	0	55,636	23,505	0	3,658	60.00
65.00	06500	0	12,854	16,123	2,444	0	65.00
66.00	06600	0	29,905	29,917	0	0	66.00
68.00	06800	0	449	0	0	0	68.00
69.00	06900	0	6,801	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	31,920	0	0	0	71.00
72.00	07200	0	9,861	0	0	0	72.00
73.00	07300	0	2,281	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	104,391	47,308	18,666	3,658	91.00
92.00	09200	0					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		0	611,625	396,123	59,139	47,233	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	198	2,186	0	0	190.00
192.00	19200	0	13,378	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	1,240	0	0	0	193.01
193.02	19302	0	14,241	515	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	0	15	0	0	0	193.04
193.05	19305	0	733	8,072	0	0	193.05
200.00		0					200.00
201.00		0	0	0	0	0	201.00
202.00		0	641,430	406,896	59,139	47,233	202.00

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
2.01	00201						2.01
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	79,090					10.00
11.00	01100	0	47,202				11.00
13.00	01300	0	2,289	80,965			13.00
14.00	01400	0	0	0	0		14.00
15.00	01500	0	0	0	0	83,237	15.00
16.00	01600	0	3,598	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	79,090	11,920	36,329	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	6,665	20,314	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	6,961	0	0	0	54.00
60.00	06000	0	4,348	0	0	0	60.00
65.00	06500	0	2,210	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	946	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	83,237	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	7,980	24,322	0	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		79,090	46,917	80,965	0	83,237	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	0	285	0	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	0	0	0	0	0	193.04
193.05	19305	0	0	0	0	0	193.05
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		79,090	47,202	80,965	0	83,237	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151309

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

Worksheet B
Part II
Date/Time Prepared:
11/29/2012 12:04 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		16.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00	
2.01	00201	CAP REL COSTS-MOB				2.01	
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	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	290,708			16.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,101	430,428	0	430,428	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	32,407	193,847	0	193,847	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	77,787	201,196	0	201,196	54.00
60.00	06000	LABORATORY	46,930	175,481	0	175,481	60.00
65.00	06500	RESPIRATORY THERAPY	3,529	69,699	0	69,699	65.00
66.00	06600	PHYSICAL THERAPY	15,828	118,222	0	118,222	66.00
68.00	06800	SPEECH PATHOLOGY	57	506	0	506	68.00
69.00	06900	ELECTROCARDIOLOGY	9,186	16,933	0	16,933	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	171	171	0	171	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,908	43,828	0	43,828	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,885	13,746	0	13,746	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,006	111,524	0	111,524	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	50,913	352,712	0	352,712	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	290,708	1,728,293	0	1,728,293	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,795	0	6,795	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	300,304	0	300,304	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	CLAY CITY MEDICAL CLINIC	0	28,787	0	28,787	193.01
193.02	19302	PUBLIC RELATIONS	0	16,082	0	16,082	193.02
193.03	19303	FOUNDATION	0	0	0	0	193.03
193.04	19304	MISSION SERVICES	0	15	0	15	193.04
193.05	19305	OTHER NON-REIMBURSABLE	0	25,096	0	25,096	193.05
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	290,708	2,105,372	0	2,105,372	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151309

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

Worksheet B-1

Date/Time Prepared:
11/29/2012 12:04 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
	BLDG & FIXT (SQURE FEET)	MVBLE EQUIP (SQURE FEET)	MOB (SQURE FEET)			
	1.00	2.00	2.01			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	82,473				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		84,265			2.00
2.01 00201	CAP REL COSTS-MOB		0	24,674		2.01
4.00 00400	EMPLOYEE BENEFITS	0	0	0	6,712,965	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	29,963	29,963	1,230	1,941,460	-5,947,581
7.00 00700	OPERATION OF PLANT	16,925	16,925	0	299,540	0
8.00 00800	LAUNDRY & LINEN SERVICE	1,769	1,769	0	0	0
9.00 00900	HOUSEKEEPING	981	981	0	147,611	0
10.00 01000	DIETARY	2,179	2,179	0	82,430	0
11.00 01100	CAFETERIA	1,236	1,236	0	90,054	0
13.00 01300	NURSING ADMINISTRATION	1,931	1,931	0	247,109	0
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	968	968	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	8,582	8,582	0	193,964	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	5,571	5,571	0	1,078,553	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,287	2,287	0	520,121	0
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,586	1,586	0	677,463	0
60.00 06000	LABORATORY	1,297	1,297	983	351,778	0
65.00 06500	RESPIRATORY THERAPY	1,564	1,564	0	176,444	0
66.00 06600	PHYSICAL THERAPY	0	0	2,902	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00 06900	ELECTROCARDIOLOGY	0	0	0	99,222	0
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	4,589	4,589	0	783,671	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	81,428	81,428	5,115	6,689,420	-5,947,581
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	212	212	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	19,559	0	0
193.00 19300	NONPAID WORKERS	0	0	0	0	0
193.01 19301	CLAY CITY MEDICAL CLINIC	0	1,792	0	0	0
193.02 19302	PUBLIC RELATIONS	50	50	0	23,545	0
193.03 19303	FOUNDATION	0	0	0	0	0
193.04 19304	MISSION SERVICES	0	0	0	0	0
193.05 19305	OTHER NON-REIMBURSABLE	783	783	0	0	0
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	448,063	1,295,347	361,962	2,300,230	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5.432845	15.372302	14.669774	0.342655	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151309

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

Worksheet B-1

Date/Time Prepared:
11/29/2012 12:04 pm

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQ. FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500	14,253,797					5.00
7.00	00700	1,217,054	39,470				7.00
8.00	00800	91,049	1,769	124,375			8.00
9.00	00900	328,036	981	4,096	8,070		9.00
10.00	01000	234,758	2,179	1,534	0	100	10.00
11.00	01100	194,332	1,236	0	0	0	11.00
13.00	01300	413,182	1,931	0	0	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	1,180,403	968	0	0	0	15.00
16.00	01600	446,416	8,582	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,671,280	5,571	38,609	4,115	100	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	928,192	2,287	19,683	2,080	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	1,240,176	1,586	16,057	625	0	54.00
60.00	06000	1,236,318	2,280	0	625	0	60.00
65.00	06500	285,630	1,564	5,140	0	0	65.00
66.00	06600	664,551	2,902	0	0	0	66.00
68.00	06800	9,973	0	0	0	0	68.00
69.00	06900	151,135	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	709,316	0	0	0	0	71.00
72.00	07200	219,135	0	0	0	0	72.00
73.00	07300	50,683	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	2,319,858	4,589	39,256	625	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		13,591,477	38,425	124,375	8,070	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	4,411	212	0	0	0	190.00
192.00	19200	297,290	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	27,547	0	0	0	0	193.01
193.02	19302	316,450	50	0	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	331	0	0	0	0	193.04
193.05	19305	16,291	783	0	0	0	193.05
200.00							200.00
201.00							201.00
202.00		5,947,581	1,724,886	206,347	514,580	430,484	202.00
203.00		0.417263	43.701191	1.659071	63.764560	4,304.840000	203.00
204.00		641,430	406,896	59,139	47,233	79,090	204.00
205.00		0.045001	10.308994	0.475489	5.852912	790.900000	205.00

Cost Center Description		CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
2.01	00201						2.01
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
11.00	01100	8,435					11.00
13.00	01300	409	4,747				13.00
14.00	01400	0	0	100			14.00
15.00	01500	0	0	0	100		15.00
16.00	01600	643	0	0	0	56,066,101	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,130	2,130	0	0	2,333,940	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,191	1,191	0	0	6,250,127	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	1,244	0	0	0	15,001,045	54.00
60.00	06000	777	0	0	0	9,051,138	60.00
65.00	06500	395	0	0	0	680,625	65.00
66.00	06600	0	0	0	0	3,052,747	66.00
68.00	06800	0	0	0	0	11,040	68.00
69.00	06900	169	0	0	0	1,771,653	69.00
70.00	07000	0	0	0	0	32,927	70.00
71.00	07100	0	0	100	0	2,296,600	71.00
72.00	07200	0	0	0	0	749,356	72.00
73.00	07300	0	0	0	100	5,015,710	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	1,426	1,426	0	0	9,819,193	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		8,384	4,747	100	100	56,066,101	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	51	0	0	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	0	0	0	0	0	193.04
193.05	19305	0	0	0	0	0	193.05
200.00							200.00
201.00							201.00
202.00		329,435	685,949	0	1,715,244	1,032,844	202.00
203.00		39.055720	144.501580	0.000000	17,152.440000	0.018422	203.00
204.00		47,202	80,965	0	83,237	290,708	204.00
205.00		5.595969	17.056035	0.000000	832.370000	0.005185	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151309

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

Worksheet C
Part I
Date/Time Prepared:
11/29/2012 12:04 pm

		Title XVIII		Hospital		Cost	
Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	Total Costs	
			Total Costs	RCE Disallowance			
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		3,803,007		3,803,007	0	0 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		1,914,478		1,914,478	0	0 50.00
53.00	05300 ANESTHESIOLOGY		0		0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,218,388		2,218,388	0	0 54.00
60.00	06000 LABORATORY		2,088,766		2,088,766	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	0	509,655		509,655	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0	1,124,903		1,124,903	0	0 66.00
68.00	06800 SPEECH PATHOLOGY	0	14,337		14,337	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY		253,435		253,435	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		607		607	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1,047,595		1,047,595	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		324,377		324,377	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,879,474		1,879,474	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY		4,036,014		4,036,014	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		773,653		773,653	0	0 92.00
200.00	Subtotal (see instructions)		19,988,689	0	19,988,689	0	0 200.00
201.00	Less Observation Beds		773,653		773,653	0	0 201.00
202.00	Total (see instructions)		19,215,036	0	19,215,036	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151309

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

Worksheet C
Part I
Date/Time Prepared:
11/29/2012 12:04 pm

		Title XVIII			Hospital	Cost	
Cost Center Description		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	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,333,940		2,333,940		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	557,846	5,692,281	6,250,127	0.306310	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	926,005	14,075,040	15,001,045	0.147882	54.00
60.00	06000	LABORATORY	971,804	8,079,334	9,051,138	0.230774	60.00
65.00	06500	RESPIRATORY THERAPY	471,164	209,461	680,625	0.748804	65.00
66.00	06600	PHYSICAL THERAPY	582,814	2,469,933	3,052,747	0.368489	66.00
68.00	06800	SPEECH PATHOLOGY	8,312	2,728	11,040	1.298641	68.00
69.00	06900	ELECTROCARDIOLOGY	351,638	1,420,015	1,771,653	0.143050	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,638	29,289	32,927	0.018435	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	623,047	1,673,553	2,296,600	0.456150	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	356,877	392,479	749,356	0.432874	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,592,522	3,423,188	5,015,710	0.374717	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	289,252	9,529,941	9,819,193	0.411033	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	663,493	663,493	1.166030	92.00
200.00		Subtotal (see instructions)	9,068,859	47,660,735	56,729,594		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	9,068,859	47,660,735	56,729,594		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151309

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

Worksheet C
Part I
Date/Time Prepared:
11/29/2012 12:04 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
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: 151309

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

Worksheet C
Part I
Date/Time Prepared:
11/29/2012 12:04 pm

Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Total Costs
			Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	3,803,007		3,803,007	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1,914,478		1,914,478	0	0	50.00
53.00 05300 ANESTHESIOLOGY	0		0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,218,388		2,218,388	0	0	54.00
60.00 06000 LABORATORY	2,088,766		2,088,766	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	509,655	0	509,655	0	0	65.00
66.00 06600 PHYSICAL THERAPY	1,124,903	0	1,124,903	0	0	66.00
68.00 06800 SPEECH PATHOLOGY	14,337	0	14,337	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	253,435		253,435	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	607		607	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,047,595		1,047,595	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	324,377		324,377	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,879,474		1,879,474	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	4,036,014		4,036,014	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	773,653		773,653	0	0	92.00
200.00 Subtotal (see instructions)	19,988,689	0	19,988,689	0	0	200.00
201.00 Less Observation Beds	773,653		773,653	0	0	201.00
202.00 Total (see instructions)	19,215,036	0	19,215,036	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151309

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

Worksheet C
Part I
Date/Time Prepared:
11/29/2012 12:04 pm

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
Title XIX Hospital Cost						
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	2,333,940		2,333,940			30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	557,846	5,692,281	6,250,127	0.306310	0.000000	50.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	926,005	14,075,040	15,001,045	0.147882	0.000000	54.00
60.00 06000 LABORATORY	971,804	8,079,334	9,051,138	0.230774	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	471,164	209,461	680,625	0.748804	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	582,814	2,469,933	3,052,747	0.368489	0.000000	66.00
68.00 06800 SPEECH PATHOLOGY	8,312	2,728	11,040	1.298641	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	351,638	1,420,015	1,771,653	0.143050	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	3,638	29,289	32,927	0.018435	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	623,047	1,673,553	2,296,600	0.456150	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	356,877	392,479	749,356	0.432874	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,592,522	3,423,188	5,015,710	0.374717	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	289,252	9,529,941	9,819,193	0.411033	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	663,493	663,493	1.166030	0.000000	92.00
200.00 Subtotal (see instructions)	9,068,859	47,660,735	56,729,594			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	9,068,859	47,660,735	56,729,594			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151309

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

Worksheet C
Part I
Date/Time Prepared:
11/29/2012 12:04 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151309

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

Worksheet D
Part II
Date/Time Prepared:
11/29/2012 12:04 pm

Cost Center Description		Title XVIII			Hospital	Cost		
		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	193,847	6,250,127	0.031015	334,974	10,389	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	201,196	15,001,045	0.013412	600,155	8,049	54.00
60.00	06000	LABORATORY	175,481	9,051,138	0.019388	513,766	9,961	60.00
65.00	06500	RESPIRATORY THERAPY	69,699	680,625	0.102404	239,997	24,577	65.00
66.00	06600	PHYSICAL THERAPY	118,222	3,052,747	0.038726	111,053	4,301	66.00
68.00	06800	SPEECH PATHOLOGY	506	11,040	0.045833	3,486	160	68.00
69.00	06900	ELECTROCARDIOLOGY	16,933	1,771,653	0.009558	43,858	419	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	171	32,927	0.005193	1,330	7	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,828	2,296,600	0.019084	352,252	6,722	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,746	749,356	0.018344	200,466	3,677	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	111,524	5,015,710	0.022235	806,186	17,926	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	352,712	9,819,193	0.035921	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	663,493	0.000000	0	0	92.00
200.00		Total (lines 50-199)	1,297,865	54,395,654		3,207,523	86,188	200.00

APPORIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151309

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2012 12:04 pm

Cost Center Description	Title XVIII				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			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151309

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2012 12:04 pm

Cost Center Description		Title XVIII			Hospital			
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	6,250,127	0.000000	0.000000	334,974	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,001,045	0.000000	0.000000	600,155	54.00
60.00	06000	LABORATORY	0	9,051,138	0.000000	0.000000	513,766	60.00
65.00	06500	RESPIRATORY THERAPY	0	680,625	0.000000	0.000000	239,997	65.00
66.00	06600	PHYSICAL THERAPY	0	3,052,747	0.000000	0.000000	111,053	66.00
68.00	06800	SPEECH PATHOLOGY	0	11,040	0.000000	0.000000	3,486	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,771,653	0.000000	0.000000	43,858	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	32,927	0.000000	0.000000	1,330	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,296,600	0.000000	0.000000	352,252	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	749,356	0.000000	0.000000	200,466	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,015,710	0.000000	0.000000	806,186	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	9,819,193	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	663,493	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	54,395,654			3,207,523	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151309

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Title XVIII			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 Cost	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151309

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2012 12:04 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151309

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

Worksheet D
Part V
Date/Time Prepared:
11/29/2012 12:04 pm

		Title XVIII		Hospital		Cost	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)			
		1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.306310	0	2,113,949	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147882	0	4,514,814	0	54.00
60.00	06000	LABORATORY	0.230774	0	3,137,831	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.748804	0	111,817	0	65.00
66.00	06600	PHYSICAL THERAPY	0.368489	0	699,259	0	66.00
68.00	06800	SPEECH PATHOLOGY	1.298641	0	1,655	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.143050	0	224,703	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.018435	0	7,775	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.456150	0	636,128	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.432874	0	290,695	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.374717	0	1,735,475	1,607	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.411033	0	2,368,059	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.166030	0	326,903	0	92.00
200.00		Subtotal (see instructions)		0	16,169,063	1,607	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	16,169,063	1,607	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151309

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

Worksheet D
Part V
Date/Time Prepared:
11/29/2012 12:04 pm

		Title XVIII			Hospital	Cost
Cost Center Description	Costs					
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)			
	5.00	6.00	7.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	647,524	0		50.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	667,660	0		54.00
60.00	06000 LABORATORY	0	724,130	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	83,729	0		65.00
66.00	06600 PHYSICAL THERAPY	0	257,669	0		66.00
68.00	06800 SPEECH PATHOLOGY	0	2,149	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	32,144	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	143	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	290,170	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	125,834	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	650,312	602		73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	973,350	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	381,179	0		92.00
200.00	Subtotal (see instructions)	0	4,835,993	602		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net charges (line 200 +/- line 201)	0	4,835,993	602		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151309

Period: From 07/01/2011

Worksheet D

Component CCN: 152309

To 06/30/2012

Part V

Date/Time Prepared: 11/29/2012 12:04 pm

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost	
			PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.306310	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147882	0	0	0	54.00
60.00	06000	LABORATORY	0.230774	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.748804	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.368489	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	1.298641	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.143050	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.018435	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.456150	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.432874	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.374717	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.411033	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.166030	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151309

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

Worksheet D
Part V
Date/Time Prepared:
11/29/2012 12:04 pm

Component CCN: 152309

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Costs			Cost	
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Subtotal (see instructions)	0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	0	202.00

Title XVIII		Hospital	Cost	
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,451	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,380	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)		1,701	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		471	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)		470	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		65	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)		65	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,298	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)		471	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)		470	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		146.75	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		146.75	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,803,007	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)		9,539	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)		9,539	25.00
26.00	Total swing-bed cost (see instructions)		1,091,244	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,711,763	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,341,452	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,341,452	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.158154	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)		1,376.51	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,711,763	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,139.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,478,928	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)		1,478,928	41.00

Cost Center Description		Title XVIII			Hospital Cost		
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					42.00	
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT					43.00	
44.00	CORONARY CARE UNIT					44.00	
45.00	BURN INTENSIVE CARE UNIT					45.00	
46.00	SURGICAL INTENSIVE CARE UNIT					46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00	
Cost Center Description							
		1.00					
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,090,930	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,569,858	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					536,653	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					535,513	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,072,166	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					679	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,139.40	88.00
89.00	observation bed cost (line 87 x line 88) (see instructions)					773,653	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151309

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

worksheet D-1

Date/Time Prepared:
11/29/2012 12:04 pm

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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151309	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/29/2012 12:04 pm
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	Title XIX	Hospital	Cost
			1.00

Cost Center Description			
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,451	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,380	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)	1,701	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)	941	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)	130	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	118	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)	22	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING-BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,803,007	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)	1,077,577	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,725,430	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)	2,341,452	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	2,341,452	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.163991	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)	1,376.51	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,725,430	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,145.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	135,127	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)	135,127	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151309

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

Worksheet D-1

Date/Time Prepared:
11/29/2012 12:04 pm

		Title XIX			Hospital	Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					235,065 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					370,192 49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0 54.00
55.00	Target amount per discharge					0.00 55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					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
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					679 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,145.14 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					777,550 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151309

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

Worksheet D-1

Date/Time Prepared:
11/29/2012 12:04 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151309

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

Worksheet D-3

Date/Time Prepared:
11/29/2012 12:04 pm

Cost Center Description		Title XVIII Hospital Cost			
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,262,411		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.306310	334,974	102,606	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.147882	600,155	88,752	54.00
60.00	06000 LABORATORY	0.230774	513,766	118,564	60.00
65.00	06500 RESPIRATORY THERAPY	0.748804	239,997	179,711	65.00
66.00	06600 PHYSICAL THERAPY	0.368489	111,053	40,922	66.00
68.00	06800 SPEECH PATHOLOGY	1.298641	3,486	4,527	68.00
69.00	06900 ELECTROCARDIOLOGY	0.143050	43,858	6,274	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.018435	1,330	25	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.456150	352,252	160,680	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.432874	200,466	86,777	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.374717	806,186	302,092	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.411033	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.166030	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		3,207,523	1,090,930	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)		3,207,523	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151309
Component CCN: 152309

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

Worksheet D-3
Date/Time Prepared:
11/29/2012 12:04 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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		361,209		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.306310	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.147882	45,005	6,655	54.00
60.00	06000 LABORATORY	0.230774	104,602	24,139	60.00
65.00	06500 RESPIRATORY THERAPY	0.748804	80,317	60,142	65.00
66.00	06600 PHYSICAL THERAPY	0.368489	398,977	147,019	66.00
68.00	06800 SPEECH PATHOLOGY	1.298641	3,456	4,488	68.00
69.00	06900 ELECTROCARDIOLOGY	0.143050	4,789	685	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.018435	781	14	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.456150	99,942	45,589	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.432874	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.374717	261,190	97,872	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.411033	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.166030	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		999,059	386,603	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)		999,059		202.00

Provider CCN: 151309

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

Worksheet D-3

Date/Time Prepared:
 11/29/2012 12:04 pm

Cost Center Description		Ratio of Cost To Charges	Hospital Cost		
			Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		242,414		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.306310	74,087	22,694	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.147882	54,892	8,118	54.00
60.00	06000 LABORATORY	0.230774	65,804	15,186	60.00
65.00	06500 RESPIRATORY THERAPY	0.748804	89,996	67,389	65.00
66.00	06600 PHYSICAL THERAPY	0.368489	14,317	5,276	66.00
68.00	06800 SPEECH PATHOLOGY	1.298641	258	335	68.00
69.00	06900 ELECTROCARDIOLOGY	0.143050	22,376	3,201	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.018435	781	14	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.456150	106,041	48,371	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.432874	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.374717	172,080	64,481	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.411033	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.166030	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		600,632	235,065	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)		600,632		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151309

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

Worksheet E
Part B
Date/Time Prepared:
11/29/2012 12:04 pm

		Title XVIII	Hospital	Cost	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			4,836,595	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0	2.00
3.00	PPS payments			0	3.00
4.00	Outlier payment (see instructions)			0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200			0	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4,836,595	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)			0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)			0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18.00	Total customary charges (see instructions)			0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			4,884,961	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance (for CAH, see instructions)			45,178	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,602,034	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			2,237,749	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)			0	28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			2,237,749	30.00
31.00	Primary payer payments			604	31.00
32.00	Subtotal (line 30 minus line 31)			2,237,145	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)					
33.00	Composite rate ESRD (from worksheet I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			307,520	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			307,520	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			307,520	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			2,544,665	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			2,544,665	40.00
41.00	Interim payments			2,666,509	41.00
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)			-121,844	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0	44.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151309

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

Worksheet E
Part B
Date/Time Prepared:
11/29/2012 12:04 pm

Title XVIII	Hospital	Cost
		overrides
		1.00

WORKSHEET OVERRIDE VALUES

112.00 | override of Ancillary service charges (line 12)

0 | 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151309

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

Worksheet E-1
Part I
Date/Time Prepared:
11/29/2012 12:04 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,945,603		2,637,160		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	03/09/2012	127,658	06/13/2012	137,230		3.01
3.02		06/13/2012	40,581		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0	03/09/2012	107,881		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		168,239		29,349		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or Wkst. E-3, line and column as appropriate)		2,113,842		2,666,509		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		183,898		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		121,844		6.02
7.00	Total Medicare program liability (see instructions)		2,297,740		2,544,665		7.00
			0	Contractor Number	Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151309

Period: From 07/01/2011

Worksheet E-1

Component CCN: 152309

To 06/30/2012

Part I

Date/Time Prepared: 11/29/2012 12:04 pm

		Title XVIII		Swing Beds - SNF		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,264,396		0		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	03/09/2012	70,997		0		3.01
3.02		06/13/2012	12,747		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		83,744		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		1,348,140		0		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		118,007		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		1,466,147		0		7.00
		0		Contractor Number 1.00		Date (Mo/Day/Yr) 2.00	
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151309
Component CCN: 152309

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

Worksheet E-2
Date/Time Prepared:
11/29/2012 12:04 pm

		Swing Beds - SNF		
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,082,888	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	390,469	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	941	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,473,357	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,473,357	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,473,357	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,210	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,466,147	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	1,466,147	0	19.00
20.00	Interim payments	1,348,140	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	118,007	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151309

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

Worksheet E-3
Part V
Date/Time Prepared:
11/29/2012 12:04 pm

		Title XVIII	Hospital	Cost	
				1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)					
1.00	Inpatient services			2,569,858	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0	2.00
3.00	Organ acquisition			0	3.00
4.00	Subtotal (sum of lines 1 thru 3)			2,569,858	4.00
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,595,557	6.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
7.00	Routine service charges			0	7.00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	9.00
10.00	Total reasonable charges			0	10.00
Customary charges					
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13.00
14.00	Total customary charges (see instructions)			0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0	16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)			0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)			0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,595,557	19.00
20.00	Deductibles (exclude professional component)			324,661	20.00
21.00	Excess reasonable cost (from line 16)			0	21.00
22.00	Subtotal (line 19 minus line 20)			2,270,896	22.00
23.00	Coinsurance			0	23.00
24.00	Subtotal (line 22 minus line 23)			2,270,896	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			26,844	25.00
26.00	Adjusted reimbursable bad debts (see instructions)			26,844	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			26,844	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,297,740	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29.00
29.99	Recovery of Accelerated Depreciation			0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)			2,297,740	30.00
31.00	Interim payments			2,113,842	31.00
32.00	Tentative settlement (for contractor use only)			0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)			183,898	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151309

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

Worksheet E-3
Part VII
Date/Time Prepared:
11/29/2012 12:04 pm

		Title XIX	Hospital	Cost	
				1.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services			370,192	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)			370,192	4.00
5.00	Inpatient primary payer payments			0	5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)			370,192	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges			2,341,452	8.00
9.00	Ancillary service charges			600,632	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)			2,942,084	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis			0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)			0.000000	15.00
16.00	Total customary charges (see instructions)			2,942,084	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			2,571,892	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			0	18.00
19.00	Interns and Residents (see instructions)			0	19.00
20.00	Cost of Teaching Physicians (see instructions)			0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)			370,192	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments			0	22.00
23.00	Outlier payments			0	23.00
24.00	Program capital payments			0	24.00
25.00	Capital exception payments (see instructions)			0	25.00
26.00	Routine and Ancillary service other pass through costs			0	26.00
27.00	Subtotal (sum of lines 22 through 26)			0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)			0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.			370,192	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)			0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			370,192	31.00
32.00	Deductibles			0	32.00
33.00	Coinsurance			0	33.00
34.00	Allowable bad debts (see instructions)			0	34.00
35.00	Utilization review			0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			370,192	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	37.00
38.00	Subtotal (line 36 ± line 37)			370,192	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)			370,192	40.00
41.00	Interim payments			370,192	41.00
42.00	Balance due provider/program (line 40 minus 41)			0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2			0	43.00

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

Provider CCN: 151309

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

Worksheet G

Date/Time Prepared:
11/29/2012 12:04 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,506,798	0	0	0	1.00
2.00	Temporary investments	10,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,315,242	0	0	0	4.00
5.00	Other receivable	978,006	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,555,775	0	0	0	6.00
7.00	Inventory	423,970	0	0	0	7.00
8.00	Prepaid expenses	234,560	0	0	0	8.00
9.00	Other current assets	29,462	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)	6,942,263	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,500	0	0	0	12.00
13.00	Land improvements	312,487	0	0	0	13.00
14.00	Accumulated depreciation	-299,803	0	0	0	14.00
15.00	Buildings	8,552,477	0	0	0	15.00
16.00	Accumulated depreciation	-3,306,292	0	0	0	16.00
17.00	Leasehold improvements	435,080	0	0	0	17.00
18.00	Accumulated depreciation	-379,547	0	0	0	18.00
19.00	Fixed equipment	2,497,198	0	0	0	19.00
20.00	Accumulated depreciation	-2,191,252	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	7,055,424	0	0	0	23.00
24.00	Accumulated depreciation	-6,042,144	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)	6,636,128	0	0	0	30.00
OTHER ASSETS						
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	27,652,970	1,398,632	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	27,652,970	1,398,632	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	41,231,361	1,398,632	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	582,211	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,486,023	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	63,046	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,445,396	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,576,676	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,997,890	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	924,161	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	8,922,051	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,498,727	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	27,732,634	0	0	0	52.00
53.00	Specific purpose fund	0	1,398,632	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)	27,732,634	1,398,632	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	41,231,361	1,398,632	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151309

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

Worksheet G-1

Date/Time Prepared:
11/29/2012 12:04 pm

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
	1.00		26,340,694		
2.00		1,653,754			2.00
3.00		27,994,448		1,431,322	3.00
4.00	201,438		0		4.00
5.00	11,072		41,336		5.00
6.00	0		56,224		6.00
7.00	0		1,546		7.00
8.00	0		21,375		8.00
9.00	112		136		9.00
10.00		212,622		120,617	10.00
11.00		28,207,070		1,551,939	11.00
12.00	474,211		0		12.00
13.00	0		78,693		13.00
14.00	0		36,492		14.00
15.00	0		38,122		15.00
16.00	225		0		16.00
17.00	0		0		17.00
18.00		474,436		153,307	18.00
19.00		27,732,634		1,398,632	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151309

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

Worksheet G-1

Date/Time Prepared:
11/29/2012 12:04 pm

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00			0		0	1.00
2.00						2.00
3.00			0		0	3.00
4.00	0			0		4.00
5.00	0			0		5.00
6.00	0			0		6.00
7.00	0			0		7.00
8.00	0			0		8.00
9.00	0			0		9.00
10.00		0			0	10.00
11.00		0			0	11.00
12.00	0			0		12.00
13.00	0			0		13.00
14.00	0			0		14.00
15.00	0			0		15.00
16.00	0			0		16.00
17.00	0			0		17.00
18.00		0			0	18.00
19.00		0			0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151309

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2012 12:04 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,491,047		2,491,047	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,491,047		2,491,047	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,491,047		2,491,047	17.00
18.00	Ancillary services	6,507,901	38,305,521	44,813,422	18.00
19.00	Outpatient services	342,458	10,318,308	10,660,766	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	CLAY CITY MEDICAL CLINIC	0	4,736	4,736	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	9,341,406	48,628,565	57,969,971	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		19,926,152		29.00
30.00	BAD DEBTS	1,945,959			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)		1,945,959		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)		21,872,111		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151309

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

Worksheet G-3

Date/Time Prepared:
11/29/2012 12:04 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	57,969,971	1.00
2.00	Less contractual allowances and discounts on patients' accounts	34,740,870	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,229,101	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,872,111	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,356,990	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,303,907	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	32,315	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	5,816	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	182,603	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	20,729	24.00
24.01	ASSETS RELEASED FROM RESTRICTION	27,050	24.01
24.02	GRANT REVENUE	1,753	24.02
24.03	NON-CASH FUNDED PENSION CURTAILMENT	470,253	24.03
24.04	MANAGEMENT FEE REVENUE	2,804	24.04
24.05	GAIN ON SALE OF PP&E	2,100	24.05
25.00	Total other income (sum of lines 6-24)	2,049,330	25.00
26.00	Total (line 5 plus line 25)	3,406,320	26.00
27.00	UNREALIZED LOSS	1,737,367	27.00
27.01	FUNDRAISING EXPENSES	15,199	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	1,752,566	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,653,754	29.00