

**ST. VINCENT FRANKFORT HOSPITAL
FRANKFORT, INDIANA**

PROVIDER NOS. 15-1316, 15-Z316 and AIM NO. 100268560A

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

June 30, 2012

ST. VINCENT FRANKFORT HOSPITAL
PROVIDER NOS. 15-1316, 15-Z316 and AIM NO. 100268560A

TABLE OF CONTENTS

Accountants' Disclaimer

Hospital Statements of Reimbursable Costs



Bradley Associates
Healthcare Advisors and CPAs

Board of Directors
St. Vincent Frankfort Hospital
Frankfort, Indiana

We have compiled the Hospital Statements of Reimbursable Costs (Titles XVIII and XIX) of St. Vincent Frankfort Hospital (Provider Nos. 15-1316, 15-Z316 and AIM NO. 100268560A) 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 financial information is intended to be filed with the Centers for Medicare and Medicaid Services and should not be used for any other purpose.

Bradley Associates

November 21, 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: 151316	Period: From 07/01/2011 To 06/30/2012	Worksheet 5 Parts I-III Date/Time Prepared: 11/21/2012 3:18 pm
--	----------------------	---	---

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 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 checked="" type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/21/2012 Time: 3:18 pm
Contractor use only	5. <input checked="" 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 checked="" type="checkbox"/> Initial Report for this Provider CCN 9. <input checked="" 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 FRANKFORT 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: 11/21/2012 Time: 3:18 pm
ectcqMyhGe6Ut9LHX2u8JISDphps.0
gdyOZ0RlTMR3lpupqWvsNU2xRosw2e
Hel00XvAvz0wD0hL
PI: Date: 11/21/2012 Time: 3:18 pm
n4hWkSI7NhPGVssiWQmFiiAgytgag0
:0jEe0xBPspu3rFmLcEWlT.tERnqf1
NNtRbmOo6i04Jfm3

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

Title

Date

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	172,591	208,937	0	0 1.00
2.00	Subprovider - IPF	0	0	0	0	0 2.00
3.00	Subprovider - IRF	0	0	0	0	0 3.00
4.00	SUBPROVIDER I	0	0	0	0	0 4.00
5.00	Swing bed - SNF	0	83,722	0	0	0 5.00
6.00	Swing bed - NF	0	0	0	0	0 6.00
7.00	SKILLED NURSING FACILITY	0	0	0	0	0 7.00
8.00	NURSING FACILITY	0	0	0	0	0 8.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	0 9.00
10.00	RURAL HEALTH CLINIC I	0	0	0	0	0 10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0 11.00
12.00	CMHC I	0	0	0	0	0 12.00
200.00	Total	0	256,313	208,937	0	0 200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151316

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

Worksheet S-2
Part I
Date/Time Prepared:
11/21/2012 3:01 pm

		1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1300 SOUTH JACKSON STREET	PO Box:		Zip Code: 46041		County: CLINTON			1.00	
2.00	City: FRANKFORT	State: IN		Zip Code: 46041		County: CLINTON			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 FRANKFORT HOSPITAL	151316	99915	1	01/21/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. VINCENT FRANKFORT HOSPITAL	152316	99915		01/21/2003	N	O	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2011	06/30/2012		20.00
21.00	Type of Control (see instructions)						2			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

X:\HFSdata\clients\Hospital\St Vincent\Frankfort\28350-12.mcrx

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151316	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/21/2012 3:01 pm		
		Beginning:	Ending:			
		1.00	2.00			
		V	XVIII	XIX		
		1.00	2.00	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.	N			58.00	
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00		
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			
62.01	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			
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				
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.		0.00	0.00	0.000000	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00

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

X:\HFSdata\clients\Hospital\St Vincent\Frankfort\28350-12.mcrx

		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 report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
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.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
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			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	Y	N	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

X:\HFSdata\clients\Hospital\St Vincent\Frankfort\28350-12.mcrx

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151316	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/21/2012 3:01 pm	
		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.	72,768	0	0	118.01
		1.00	2.00		
118.02	Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.	N	N		120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00
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			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	
142.00	Street: 10330 N. MERIDIAN ST. SUITE 420	PO Box:			
143.00	City: INDIANAPOLIS	State:		Zip Code: 46290	
		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: 151316

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

Worksheet S-2
Part I
Date/Time Prepared:
11/21/2012 3:01 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)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N		11.00
			Y/N	
			1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		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	10/10/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

	Description	Part A			
		Y/N	Date		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N			21.00
				1.00	
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	10/10/2012	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: 151316

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

Worksheet S-3
Part I
Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
	Line Number		Available		
	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	62,544.00	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	62,544.00	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	43.00				13.00
14.00 Total (see instructions)		25	9,150	62,544.00	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

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	1,421	400	2,606		1.00
2.00 HMO		96	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	682	0	682		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	98		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,103	400	3,386		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	0		242	432		13.00
14.00 Total (see instructions)	0	2,103	642	3,818		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	656		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				26		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: 151316

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

Worksheet S-3
Part I
Date/Time Prepared:
11/21/2012 3:01 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	360	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	161.46	0.00	0	360	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	161.46	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)	178	910	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)	178	910	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: 151316

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

Worksheet S-10

Date/Time Prepared:
11/21/2012 3:01 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)			0.329247	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			2,495,405	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			506,680	5.00
6.00	Medicaid charges			12,807,476	6.00
7.00	Medicaid cost (line 1 times line 6)			4,216,823	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)			1,214,738	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			55,214	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			1,214,738	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	3,379,697	74,215	3,453,912	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,112,755	24,435	1,137,190	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,112,755	24,435	1,137,190	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			3,644,971	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			339,529	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)			3,305,442	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)			1,088,307	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			2,225,497	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			3,440,235	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151316

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

Worksheet A

Date/Time Prepared:
11/21/2012 3:01 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 NEW CAP REL COSTS-BLDG & FIXT		966,025	966,025	0	966,025	1.00	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		861,789	861,789	-2,274	859,515	2.00	
3.00 00300 OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00	
4.00 00400 EMPLOYEE BENEFITS	255,753	2,523,702	2,779,455	0	2,779,455	4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	2,201,617	3,030,517	5,232,134	2,274	5,234,408	5.00	
7.00 00700 OPERATION OF PLANT	229,641	1,295,019	1,524,660	0	1,524,660	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	0	96,325	96,325	0	96,325	8.00	
9.00 00900 HOUSEKEEPING	167,047	274,121	441,168	0	441,168	9.00	
10.00 01000 DIETARY	180,539	439,444	619,983	-486,129	133,854	10.00	
11.00 01100 CAFETERIA	0	0	0	486,129	486,129	11.00	
13.00 01300 NURSING ADMINISTRATION	837,194	47,774	884,968	0	884,968	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	142,654	41,176	183,830	0	183,830	14.00	
15.00 01500 PHARMACY	267,352	698,628	965,980	0	965,980	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	10,200	49,290	59,490	0	59,490	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	1,776,194	187,585	1,963,779	-487,765	1,476,014	30.00	
43.00 04300 NURSERY	0	0	0	169,556	169,556	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	459,834	1,155,371	1,615,205	0	1,615,205	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	318,209	318,209	52.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	637,743	331,028	968,771	0	968,771	54.00	
57.00 05700 CT SCAN	0	0	0	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	683,956	914,562	1,598,518	0	1,598,518	60.00	
65.00 06500 RESPIRATORY THERAPY	169,576	128,837	298,413	0	298,413	65.00	
66.00 06600 PHYSICAL THERAPY	2,550	779,825	782,375	0	782,375	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	56,281	291	56,572	0	56,572	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
71.30 07101 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	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	886,972	753,853	1,640,825	0	1,640,825	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	8,965,103	14,575,162	23,540,265	0	23,540,265	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
194.00 07950 OTHER NONREIMBURSABLE - CLINIC	82,057	178,307	260,364	0	260,364	194.00	
194.01 07951 OTHER NONREIMBURSABLE - FOUNDATION	0	1,533	1,533	0	1,533	194.01	
194.02 07952 OTHER NONREIMBURSABLE - MARKETING	0	5	5	0	5	194.02	
200.00	TOTAL (SUM OF LINES 118-199)	9,047,160	14,755,007	23,802,167	0	23,802,167	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151316

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

Worksheet A

Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-11,014	955,011	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	272,807	1,132,322	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS	160,880	2,940,335	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-455,465	4,778,943	5.00
7.00	00700 OPERATION OF PLANT	42,750	1,567,410	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	96,325	8.00
9.00	00900 HOUSEKEEPING	0	441,168	9.00
10.00	01000 DIETARY	0	133,854	10.00
11.00	01100 CAFETERIA	-116,001	370,128	11.00
13.00	01300 NURSING ADMINISTRATION	-3,185	881,783	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-15	183,815	14.00
15.00	01500 PHARMACY	-19,637	946,343	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-7,294	52,196	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-35	1,475,979	30.00
43.00	04300 NURSERY	0	169,556	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-499,695	1,115,510	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	318,209	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	968,771	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	1,598,518	60.00
65.00	06500 RESPIRATORY THERAPY	0	298,413	65.00
66.00	06600 PHYSICAL THERAPY	-14,560	767,815	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	56,572	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
71.30	07101 IMPL. DEV. CHARGED TO PATIENT	0	0	71.30
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	-28,318	1,612,507	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-678,782	22,861,483	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950 OTHER NONREIMBURSABLE - CLINIC	0	260,364	194.00
194.01	07951 OTHER NONREIMBURSABLE - FOUNDATION	0	1,533	194.01
194.02	07952 OTHER NONREIMBURSABLE - MARKETING	326,682	326,687	194.02
200.00	TOTAL (SUM OF LINES 118-199)	-352,100	23,450,067	200.00

Provider CCN: 151316

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

Worksheet A-6

Date/Time Prepared:
11/21/2012 3:01 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	141,561	344,568	1.00	
	TOTALS		141,561	344,568		
B - NURSERY AND L&D RECLASS						
1.00	NURSERY	43.00	149,586	19,970	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	280,731	37,478	2.00	
	TOTALS		430,317	57,448		
C - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,274	1.00	
	TOTALS		0	2,274		
500.00	Grand Total: Increases		571,878	404,290	500.00	

Provider CCN: 151316

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

Worksheet A-6

Date/Time Prepared:
11/21/2012 3:01 pm

		Decreases				wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - CAFETERIA RECLASS							
1.00	DIETARY	10.00	141,561	344,568	0		1.00
	TOTALS		141,561	344,568			
B - NURSERY AND L&D RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	430,317	57,448	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		430,317	57,448			
C - INTEREST							
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2,274	9		1.00
	TOTALS		0	2,274			
500.00	Grand Total: Decreases		571,878	404,290			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151316

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/21/2012 3:01 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	140,146	20,000	0	20,000	0
2.00	Land Improvements	66,241	0	0	0	0
3.00	Buildings and Fixtures	1,118,143	163,813	0	163,813	0
4.00	Building Improvements	603,153	0	0	0	0
5.00	Fixed Equipment	718,601	21,725	0	21,725	0
6.00	Movable Equipment	5,502,081	649,147	0	649,147	70,873
7.00	HIT designated Assets	0	0	0	0	0
8.00	Subtotal (sum of lines 1-7)	8,148,365	854,685	0	854,685	70,873
9.00	Reconciling Items	0	0	0	0	0
10.00	Total (line 8 minus line 9)	8,148,365	854,685	0	854,685	70,873
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	NEW CAP REL COSTS-BLDG & FIXT	966,025	0	0	0	0
2.00	NEW CAP REL COSTS-MVBLE EQUIP	861,789	0	0	0	0
3.00	Total (sum of lines 1-2)	1,827,814	0	0	0	0
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	NEW CAP REL COSTS-BLDG & FIXT	1,281,956	0	1,281,956	0.174124	0
2.00	NEW CAP REL COSTS-MVBLE EQUIP	6,080,355	0	6,080,355	0.825876	0
3.00	Total (sum of lines 1-2)	7,362,311	0	7,362,311	1.000000	0

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151316

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/21/2012 3:01 pm

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	160,146	0		1.00	
2.00	Land Improvements	66,241	0		2.00	
3.00	Buildings and Fixtures	1,281,956	0		3.00	
4.00	Building Improvements	603,153	0		4.00	
5.00	Fixed Equipment	740,326	0		5.00	
6.00	Movable Equipment	6,080,355	0		6.00	
7.00	HIT designated Assets	0	0		7.00	
8.00	Subtotal (sum of lines 1-7)	8,932,177	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	8,932,177	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	NEW CAP REL COSTS-BLDG & FIXT	0	966,025		1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	861,789		2.00	
3.00	Total (sum of lines 1-2)	0	1,827,814		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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	955,011	0
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,148,793	0
3.00	Total (sum of lines 1-2)	0	0	0	2,103,804	0

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151316

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

worksheet A-7
Parts I-III
Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	955,011	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-16,471	0	0	0	1,132,322	2.00
3.00	Total (sum of lines 1-2)	-16,471	0	0	0	2,087,333	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted	
			Cost Center	Line #
	1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-14,595	NEW CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00 Investment income - other (chapter 2)	B	-2,015	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)		0		0.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-2,793	ADMINISTRATIVE & GENERAL	5.00 7.00
8.00 Television and radio service (chapter 21)	A	-2,509	ADMINISTRATIVE & GENERAL	5.00 8.00
9.00 Parking lot (chapter 21)		0		0.00 9.00
10.00 Provider-based physician adjustment	A-8-2	-559,321		10.00 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	436,540		12.00 12.00
13.00 Laundry and linen service		0		0.00 13.00
14.00 Cafeteria-employees and guests	B	-116,001	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	-19,637	PHARMACY	15.00 17.00
18.00 Sale of medical records and abstracts	B	-7,294	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00 28.00
29.00 Physicians' assistant		0		0.00 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00 32.00
33.00 MISC INCOME	B	-15	CENTRAL SERVICES & SUPPLY	14.00 33.00
33.01 MISC INCOME	B	-3,185	NURSING ADMINISTRATION	13.00 33.01
33.02 MISC INCOME	B	-5,564	ADMINISTRATIVE & GENERAL	5.00 33.02
33.03 ATHLETIC TRAINER	A	-13,625	PHYSICAL THERAPY	66.00 33.03
33.04 DONATION EXPENSE	A	-40	EMPLOYEE BENEFITS	4.00 33.04
33.05 DONATION EXPENSE	A	-9,241	ADMINISTRATIVE & GENERAL	5.00 33.05
33.06 MISC NON-ALLOWABLE EXPENSE	A	-35	ADULTS & PEDIATRICS	30.00 33.06
33.07 LOSS ON FIXED ASSET	A	-11,014	NEW CAP REL COSTS-BLDG & FIXT	1.00 33.07
33.09 LOBBYING	A	-696	ADMINISTRATIVE & GENERAL	5.00 33.09
33.10 INCENTIVE	A	-19,495	ADMINISTRATIVE & GENERAL	5.00 33.10
33.11 INCENTIVE	A	-1,565	EMPLOYEE BENEFITS	4.00 33.11
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-352,100		50.00

Cost Center Description	5.00	Wkst. A-7 Ref.	
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		11	2.00
3.00 Investment income - other (chapter 2)		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0	7.00
8.00 Television and radio service (chapter 21)		0	8.00
9.00 Parking lot (chapter 21)		0	9.00
10.00 Provider-based physician adjustment		0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0	11.00
12.00 Related organization transactions (chapter 10)		0	12.00
13.00 Laundry and linen service		0	13.00
14.00 Cafeteria-employees and guests		0	14.00
15.00 Rental of quarters to employee and others		0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0	16.00
17.00 Sale of drugs to other than patients		0	17.00
18.00 Sale of medical records and abstracts		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0	19.00
20.00 Vending machines		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	27.00
28.00 Non-physician Anesthetist			28.00
29.00 Physicians' assistant		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0	32.00
33.00 MISC INCOME		0	33.00
33.01 MISC INCOME		0	33.01
33.02 MISC INCOME		0	33.02
33.03 ATHLETIC TRAINER		0	33.03
33.04 DONATION EXPENSE		0	33.04
33.05 DONATION EXPENSE		0	33.05
33.06 MISC NON-ALLOWABLE EXPENSE		0	33.06
33.07 LOSS ON FIXED ASSET		9	33.07
33.09 LOBBYING		0	33.09
33.10 INCENTIVE		0	33.10
33.11 INCENTIVE		0	33.11
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: 151316

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

Worksheet A-8-1

Date/Time Prepared:
11/21/2012 3:01 pm

	Line No.		Cost Center	Expense Items	
	1.00	2.00			
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		2.00	NEW CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2.00
3.00		4.00	EMPLOYEE BENEFITS	HOME OFFICE	3.00
4.00		194.02	OTHER NONREIMBURSABLE - MARKETING	HOME OFFICE	4.00
4.01		4.00	EMPLOYEE BENEFITS	HOME OFFICE - SELF INSURANCE	4.01
4.02		4.00	EMPLOYEE BENEFITS	SVH CHARGEBACK	4.02
4.03		5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACK	4.03
4.04		9.00	HOUSEKEEPING	SVH CHARGEBACK	4.04
4.05		14.00	CENTRAL SERVICES & SUPPLY	SVH CHARGEBACK	4.05
4.06		16.00	MEDICAL RECORDS & LIBRARY	SVH CHARGEBACK	4.06
4.07		30.00	ADULTS & PEDIATRICS	SVH CHARGEBACK	4.07
4.08		54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACK	4.08
4.09		65.00	RESPIRATORY THERAPY	SVH CHARGEBACK	4.09
4.10		194.00	OTHER NONREIMBURSABLE - CLINIC	SVH CHARGEBACK	4.10
4.11		2.00	NEW CAP REL COSTS-MVBLE EQUIP	ASCENSION - INTEREST	4.11
4.12		5.00	ADMINISTRATIVE & GENERAL	ASCENSION - INTEREST	4.12
4.13		7.00	OPERATION OF PLANT	ASCENSION - TRIMEDX	4.13
4.14		4.00	EMPLOYEE BENEFITS	PENSION	4.14
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		0.00	6.00
7.00		G		0.00	7.00
8.00				0.00	8.00
9.00				0.00	9.00
10.00				0.00	10.00
100.00	G. Other (financial or non-financial) specify:		HOME OFFICE		100.00

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

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

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

Provider CCN: 151316

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

Worksheet A-8-1

Date/Time Prepared: 11/21/2012 3:01 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	289,278	0	289,278	9	1.00	
2.00	1,683,209	2,065,729	-382,520	0	2.00	
3.00	0	121,679	-121,679	0	3.00	
4.00	326,682	0	326,682	9	4.00	
4.01	1,243,875	959,711	284,164	0	4.01	
4.02	348,143	348,143	0	0	4.02	
4.03	1,136,975	1,136,975	0	0	4.03	
4.04	-60,432	-60,432	0	0	4.04	
4.05	33,113	33,113	0	0	4.05	
4.06	56,988	56,988	0	0	4.06	
4.07	50	50	0	0	4.07	
4.08	25,729	25,729	0	0	4.08	
4.09	95,575	95,575	0	0	4.09	
4.10	-780	-780	0	0	4.10	
4.11	14,595	16,471	-1,876	11	4.11	
4.12	2,015	2,274	-259	0	4.12	
4.13	431,845	389,095	42,750	0	4.13	
4.14	223,716	223,716	0	0	4.14	
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	5,850,576	5,414,036	436,540	0	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 HEALTH	100.00	HOSPITAL MGMT.	6.00
7.00	ASCENSION	100.00	HOSPITAL MGMT.	7.00
8.00		0.00		8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151316

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

Worksheet A-8-2
Date/Time Prepared:
11/21/2012 3:01 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	30,373	30,373	1.00
2.00	50.00	OPERATING ROOM	499,695	499,695	2.00
3.00	66.00	PHYSICAL THERAPY	935	935	3.00
4.00	91.00	EMERGENCY	538,966	28,318	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			1,069,969	559,321	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151316

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

Worksheet A-8-2

Date/Time Prepared:
11/21/2012 3:01 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	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	510,648	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	510,648		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151316

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

Worksheet A-8-2

Date/Time Prepared:
11/21/2012 3:01 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151316

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

Worksheet A-8-2

Date/Time Prepared:
11/21/2012 3:01 pm

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	30,373	1.00
2.00	0	499,695	2.00
3.00	0	935	3.00
4.00	0	28,318	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	559,321	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY		Provider CCN: 151316		Period: From 07/01/2011 To 06/30/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/21/2012 3:01 pm	
OUTSIDE SUPPLIERS				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)					603	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)					0	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	0.00	8,189.00	680.00	2,914.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	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)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					597,551	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					37,210	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					634,761	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					141,737	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)					776,498	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)					776,498	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)					22,003	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					22,003	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)					3,317	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					25,320	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)					25,320	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

X:\HFSdata\clients\Hospital\St Vincent\Frankfort\28350-12.mcrx

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151316	Period: From 07/01/2011 To 06/30/2012	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/21/2012 3:01 pm
--	----------------------	---	--

		Physical Therapy				Cost	
						1.00	
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	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					776,498	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					25,320	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)					801,818	63.00
64.00	Total cost of outside supplier services (from your records)					734,861	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					22,003	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					3,317	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					25,320	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					3,317	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					3,317	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: 151316

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

Worksheet B
Part I
Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	955,011	955,011			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	1,132,322		1,132,322		2.00
4.00 00400	EMPLOYEE BENEFITS	2,940,335	10,067	11,936	2,962,338	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,778,943	72,975	86,523	741,857	5,680,298
7.00 00700	OPERATION OF PLANT	1,567,410	99,978	118,541	77,379	1,863,308
8.00 00800	LAUNDRY & LINEN SERVICE	96,325	7,593	9,003	0	112,921
9.00 00900	HOUSEKEEPING	441,168	17,666	20,946	56,288	536,068
10.00 01000	DIETARY	133,854	24,043	28,507	13,134	199,538
11.00 01100	CAFETERIA	370,128	11,307	13,407	47,700	442,542
13.00 01300	NURSING ADMINISTRATION	881,783	22,438	26,604	282,099	1,212,924
14.00 01400	CENTRAL SERVICES & SUPPLY	183,815	32,524	38,562	48,068	302,969
15.00 01500	PHARMACY	946,343	16,748	19,858	90,086	1,073,035
16.00 01600	MEDICAL RECORDS & LIBRARY	52,196	18,967	22,489	3,437	97,089
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,475,979	150,752	178,741	453,504	2,258,976
43.00 04300	NURSERY	169,556	3,034	3,597	50,404	226,591
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,115,510	63,710	75,539	154,945	1,409,704
52.00 05200	DELIVERY ROOM & LABOR ROOM	318,209	13,283	15,749	94,595	441,836
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	968,771	44,542	52,812	214,893	1,281,018
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	1,598,518	18,937	22,453	230,464	1,870,372
65.00 06500	RESPIRATORY THERAPY	298,413	9,374	11,115	57,140	376,042
66.00 06600	PHYSICAL THERAPY	767,815	19,976	23,685	859	812,335
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	56,572	3,520	4,173	18,964	83,229
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
71.30 07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	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	1,612,507	31,363	37,185	298,872	1,979,927
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	22,861,483	692,797	821,425	2,934,688	22,260,722
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,295	3,907	0	7,202
194.00 07950	OTHER NONREIMBURSABLE - CLINIC	260,364	255,290	302,687	27,650	845,991
194.01 07951	OTHER NONREIMBURSABLE - FOUNDATION	1,533	3,629	4,303	0	9,465
194.02 07952	OTHER NONREIMBURSABLE - MARKETING	326,687	0	0	0	326,687
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	23,450,067	955,011	1,132,322	2,962,338	23,450,067

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151316

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

Worksheet B
Part I
Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	5,680,298					5.00
7.00	00700	595,627	2,458,935				7.00
8.00	00800	36,096	24,185	173,202			8.00
9.00	00900	171,360	56,270	0	763,698		9.00
10.00	01000	63,785	76,582	2,629	24,589	367,123	10.00
11.00	01100	141,463	36,016	0	11,564	0	11.00
13.00	01300	387,724	71,470	0	22,948	0	13.00
14.00	01400	96,847	103,594	2,010	33,263	0	14.00
15.00	01500	343,007	53,346	0	17,129	0	15.00
16.00	01600	31,036	60,414	0	19,398	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	722,105	480,173	64,609	154,177	367,123	30.00
43.00	04300	72,432	9,662	0	3,102	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	450,627	202,928	20,009	65,157	0	50.00
52.00	05200	141,238	42,309	0	13,585	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	409,491	141,875	0	45,554	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	597,885	60,317	0	19,367	0	60.00
65.00	06500	120,206	29,858	0	9,587	0	65.00
66.00	06600	259,672	63,628	35,216	20,430	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	26,605	11,211	0	3,600	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
71.30	07101	0	0	0	0	0	71.30
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	632,905	99,896	19,129	32,075	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		5,300,111	1,623,734	143,602	495,525	367,123	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	2,302	10,495	0	3,370	0	190.00
194.00	07950	270,430	813,146	29,600	261,091	0	194.00
194.01	07951	3,026	11,560	0	3,712	0	194.01
194.02	07952	104,429	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		5,680,298	2,458,935	173,202	763,698	367,123	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151316

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

Worksheet B
Part I
Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	631,585					11.00
13.00	01300	69,770	1,764,836				13.00
14.00	01400	24,385	0	563,068			14.00
15.00	01500	22,851	0	2,634	1,512,002		15.00
16.00	01600	776	0	81	0	208,794	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	159,298	557,726	122,187	0	13,182	30.00
43.00	04300	14,035	49,138	17,385	0	1,683	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	48,526	169,896	146,907	0	27,726	50.00
52.00	05200	26,342	92,227	32,627	0	3,156	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	62,014	217,121	28,767	0	44,304	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	73,508	257,359	39,590	0	37,986	60.00
65.00	06500	16,095	56,351	1,994	0	9,924	65.00
66.00	06600	44	154	2,010	0	12,489	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	4,414	15,453	0	0	380	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
71.30	07101	0	0	0	0	0	71.30
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	1,512,002	24,928	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	99,800	349,411	158,754	0	33,036	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		621,858	1,764,836	552,936	1,512,002	208,794	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	9,727	0	10,123	0	0	194.00
194.01	07951	0	0	9	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		631,585	1,764,836	563,068	1,512,002	208,794	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151316

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

Worksheet B
Part I
Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,899,556	0	4,899,556
43.00	04300	NURSERY	394,028	0	394,028
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,541,480	0	2,541,480
52.00	05200	DELIVERY ROOM & LABOR ROOM	793,320	0	793,320
53.00	05300	ANESTHESIOLOGY	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,230,144	0	2,230,144
57.00	05700	CT SCAN	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0
60.00	06000	LABORATORY	2,956,384	0	2,956,384
65.00	06500	RESPIRATORY THERAPY	620,057	0	620,057
66.00	06600	PHYSICAL THERAPY	1,205,978	0	1,205,978
67.00	06700	OCCUPATIONAL THERAPY	0	0	0
68.00	06800	SPEECH PATHOLOGY	144,892	0	144,892
69.00	06900	ELECTROCARDIOLOGY	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,536,930	0	1,536,930
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	3,404,933	0	3,404,933
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,727,702	0	20,727,702
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,369	0	23,369
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	2,240,108	0	2,240,108
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	27,772	0	27,772
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	431,116	0	431,116
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118-201)	23,450,067	0	23,450,067

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151316

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

Worksheet B
Part II
Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	10,067	11,936	22,003	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	72,975	86,523	159,498	5.00
7.00 00700	OPERATION OF PLANT	0	99,978	118,541	218,519	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	7,593	9,003	16,596	8.00
9.00 00900	HOUSEKEEPING	0	17,666	20,946	38,612	9.00
10.00 01000	DIETARY	0	24,043	28,507	52,550	10.00
11.00 01100	CAFETERIA	0	11,307	13,407	24,714	11.00
13.00 01300	NURSING ADMINISTRATION	0	22,438	26,604	49,042	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	32,524	38,562	71,086	14.00
15.00 01500	PHARMACY	0	16,748	19,858	36,606	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	18,967	22,489	41,456	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	150,752	178,741	329,493	30.00
43.00 04300	NURSERY	0	3,034	3,597	6,631	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	63,710	75,539	139,249	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	13,283	15,749	29,032	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	44,542	52,812	97,354	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	18,937	22,453	41,390	60.00
65.00 06500	RESPIRATORY THERAPY	0	9,374	11,115	20,489	65.00
66.00 06600	PHYSICAL THERAPY	0	19,976	23,685	43,661	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	3,520	4,173	7,693	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
71.30 07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	71.30
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	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	31,363	37,185	68,548	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)	0	692,797	821,425	1,514,222	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,295	3,907	7,202	190.00
194.00 07950	OTHER NONREIMBURSABLE - CLINIC	0	255,290	302,687	557,977	194.00
194.01 07951	OTHER NONREIMBURSABLE - FOUNDATION	0	3,629	4,303	7,932	194.01
194.02 07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	194.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	955,011	1,132,322	2,087,333	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151316

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

Worksheet B
Part II
Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	165,008					5.00
7.00	00700	17,303	236,397				7.00
8.00	00800	1,049	2,325	19,970			8.00
9.00	00900	4,978	5,410	0	49,418		9.00
10.00	01000	1,853	7,362	303	1,591	63,757	10.00
11.00	01100	4,109	3,462	0	748	0	11.00
13.00	01300	11,263	6,871	0	1,485	0	13.00
14.00	01400	2,813	9,959	232	2,152	0	14.00
15.00	01500	9,964	5,129	0	1,108	0	15.00
16.00	01600	902	5,808	0	1,255	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	20,973	46,163	7,449	9,977	63,757	30.00
43.00	04300	2,104	929	0	201	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	13,091	19,509	2,307	4,216	0	50.00
52.00	05200	4,103	4,067	0	879	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	11,896	13,640	0	2,948	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	17,368	5,799	0	1,253	0	60.00
65.00	06500	3,492	2,871	0	620	0	65.00
66.00	06600	7,543	6,117	4,060	1,322	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	773	1,078	0	233	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
71.30	07101	0	0	0	0	0	71.30
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	18,386	9,604	2,206	2,076	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		153,963	156,103	16,557	32,064	63,757	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	67	1,009	0	218	0	190.00
194.00	07950	7,856	78,174	3,413	16,896	0	194.00
194.01	07951	88	1,111	0	240	0	194.01
194.02	07952	3,034	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		165,008	236,397	19,970	49,418	63,757	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151316

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

Worksheet B
Part II
Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	33,387					11.00
13.00	01300	3,688	74,444				13.00
14.00	01400	1,289	0	87,888			14.00
15.00	01500	1,208	0	411	55,095		15.00
16.00	01600	41	0	13	0	49,501	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	8,421	23,524	19,072	0	3,127	30.00
43.00	04300	742	2,073	2,714	0	399	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,565	7,167	22,930	0	6,577	50.00
52.00	05200	1,393	3,890	5,093	0	749	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	3,278	9,159	4,490	0	10,480	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	3,886	10,856	6,180	0	9,011	60.00
65.00	06500	851	2,377	311	0	2,354	65.00
66.00	06600	2	7	314	0	2,963	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	233	652	0	0	90	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
71.30	07101	0	0	0	0	0	71.30
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	55,095	5,914	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	5,276	14,739	24,779	0	7,837	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		32,873	74,444	86,307	55,095	49,501	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	514	0	1,580	0	0	194.00
194.01	07951	0	0	1	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		33,387	74,444	87,888	55,095	49,501	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151316

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

Worksheet B
Part II
Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	535,325	0	535,325
43.00	04300	NURSERY	16,167	0	16,167
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	218,762	0	218,762
52.00	05200	DELIVERY ROOM & LABOR ROOM	49,909	0	49,909
53.00	05300	ANESTHESIOLOGY	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	154,841	0	154,841
57.00	05700	CT SCAN	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0
60.00	06000	LABORATORY	97,455	0	97,455
65.00	06500	RESPIRATORY THERAPY	33,789	0	33,789
66.00	06600	PHYSICAL THERAPY	65,995	0	65,995
67.00	06700	OCCUPATIONAL THERAPY	0	0	0
68.00	06800	SPEECH PATHOLOGY	10,893	0	10,893
69.00	06900	ELECTROCARDIOLOGY	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	61,009	0	61,009
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	155,671	0	155,671
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,399,816	0	1,399,816
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,496	0	8,496
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	666,615	0	666,615
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	9,372	0	9,372
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	3,034	0	3,034
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118-201)	2,087,333	0	2,087,333

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151316

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

Worksheet B-1

Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	157,095					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		157,095				2.00
4.00 00400	EMPLOYEE BENEFITS	1,656	1,656	8,791,407			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	12,004	12,004	2,201,617	-5,680,298	17,769,769	5.00
7.00 00700	OPERATION OF PLANT	16,446	16,446	229,641	0	1,863,308	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,249	1,249	0	0	112,921	8.00
9.00 00900	HOUSEKEEPING	2,906	2,906	167,047	0	536,068	9.00
10.00 01000	DIETARY	3,955	3,955	38,978	0	199,538	10.00
11.00 01100	CAFETERIA	1,860	1,860	141,561	0	442,542	11.00
13.00 01300	NURSING ADMINISTRATION	3,691	3,691	837,194	0	1,212,924	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	5,350	5,350	142,654	0	302,969	14.00
15.00 01500	PHARMACY	2,755	2,755	267,352	0	1,073,035	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,120	3,120	10,200	0	97,089	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	24,798	24,798	1,345,877	0	2,258,976	30.00
43.00 04300	NURSERY	499	499	149,586	0	226,591	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	10,480	10,480	459,834	0	1,409,704	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,185	2,185	280,731	0	441,836	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	7,327	7,327	637,743	0	1,281,018	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	3,115	3,115	683,956	0	1,870,372	60.00
65.00 06500	RESPIRATORY THERAPY	1,542	1,542	169,576	0	376,042	65.00
66.00 06600	PHYSICAL THERAPY	3,286	3,286	2,550	0	812,335	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	579	579	56,281	0	83,229	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
71.30 07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	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	5,159	5,159	886,972	0	1,979,927	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	113,962	113,962	8,709,350	-5,680,298	16,580,424	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	542	542	0	0	7,202	190.00
194.00 07950	OTHER NONREIMBURSABLE - CLINIC	41,994	41,994	82,057	0	845,991	194.00
194.01 07951	OTHER NONREIMBURSABLE - FOUNDATION	597	597	0	0	9,465	194.01
194.02 07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	326,687	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	955,011	1,132,322	2,962,338		5,680,298	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	6.079194	7.207881	0.336958		0.319661	203.00
204.00	Cost to be allocated (per wkst. B, Part II)			22,003		165,008	204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.002503		0.009286	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151316

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

Worksheet B-1

Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	126,989				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,249	15,945			8.00
9.00	00900	HOUSEKEEPING	2,906	0	122,834		9.00
10.00	01000	DIETARY	3,955	242	3,955	13,356	10.00
11.00	01100	CAFETERIA	1,860	0	1,860	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,691	0	3,691	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,350	185	5,350	0	14.00
15.00	01500	PHARMACY	2,755	0	2,755	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,120	0	3,120	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	24,798	5,948	24,798	13,356	30.00
43.00	04300	NURSERY	499	0	499	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,480	1,842	10,480	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,185	0	2,185	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,327	0	7,327	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	3,115	0	3,115	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,542	0	1,542	0	65.00
66.00	06600	PHYSICAL THERAPY	3,286	3,242	3,286	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	579	0	579	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	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	5,159	1,761	5,159	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	83,856	13,220	79,701	13,356	211,613
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	542	0	542	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	41,994	2,725	41,994	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	597	0	597	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,458,935	173,202	763,698	367,123	631,585
203.00		Unit cost multiplier (Wkst. B, Part I)	19.363370	10.862465	6.217318	27.487496	2.938657
204.00		Cost to be allocated (per Wkst. B, Part II)	236,397	19,970	49,418	63,757	33,387
205.00		Unit cost multiplier (Wkst. B, Part II)	1.861555	1.252430	0.402315	4.773660	0.155344

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151316

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

Worksheet B-1

Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	171,533				13.00
14.00	01400	0	305,028			14.00
15.00	01500	0	1,427	100		15.00
16.00	01600	0	44	0	65,422,807	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	54,208	66,192	0	4,130,852	30.00
43.00	04300	4,776	9,418	0	527,408	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	16,513	79,583	0	8,688,734	50.00
52.00	05200	8,964	17,675	0	988,919	52.00
53.00	05300	0	0	0	0	53.00
54.00	05400	21,103	15,584	0	13,875,168	54.00
57.00	05700	0	0	0	0	57.00
58.00	05800	0	0	0	0	58.00
59.00	05900	0	0	0	0	59.00
60.00	06000	25,014	21,447	0	11,904,088	60.00
65.00	06500	5,477	1,080	0	3,110,109	65.00
66.00	06600	15	1,089	0	3,913,791	66.00
67.00	06700	0	0	0	0	67.00
68.00	06800	1,502	0	0	118,987	68.00
69.00	06900	0	0	0	0	69.00
71.00	07100	0	0	0	0	71.00
71.30	07101	0	0	0	0	71.30
72.00	07200	0	0	0	0	72.00
73.00	07300	0	0	100	7,811,989	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	33,961	86,000	0	10,352,762	91.00
92.00	09200					92.00
SPECIAL PURPOSE COST CENTERS						
118.00		171,533	299,539	100	65,422,807	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
194.00	07950	0	5,484	0	0	194.00
194.01	07951	0	5	0	0	194.01
194.02	07952	0	0	0	0	194.02
200.00						200.00
201.00						201.00
202.00		1,764,836	563,068	1,512,002	208,794	202.00
203.00		10.288609	1.845955	15,120.020000	0.003191	203.00
204.00		74,444	87,888	55,095	49,501	204.00
205.00		0.433992	0.288131	550.950000	0.000757	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151316

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

Worksheet C
Part I
Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance		Total Costs	
				1.00	2.00		3.00	4.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,899,556		4,899,556	0	0	30.00
43.00	04300	NURSERY	394,028		394,028	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,541,480		2,541,480	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	793,320		793,320	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,230,144		2,230,144	0	0	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	2,956,384		2,956,384	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	620,057	0	620,057	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,205,978	0	1,205,978	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	144,892	0	144,892	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0		0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,536,930		1,536,930	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,404,933		3,404,933	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	812,548		812,548	0	0	92.00
200.00		Subtotal (see instructions)	21,540,250	0	21,540,250	0	0	200.00
201.00		Less Observation Beds	812,548		812,548	0	0	201.00
202.00		Total (see instructions)	20,727,702	0	20,727,702	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151316

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

Worksheet C
Part I
Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description		Title XVIII			Hospital	Cost	
		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
6.00	7.00	8.00	9.00	10.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,521,482		3,521,482		30.00
43.00	04300	NURSERY	527,408		527,408		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,664,626	7,024,108	8,688,734	0.292503	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	956,972	31,947	988,919	0.802209	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	791,944	13,083,224	13,875,168	0.160729	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,017,151	10,886,937	11,904,088	0.248350	60.00
65.00	06500	RESPIRATORY THERAPY	1,107,871	2,002,238	3,110,109	0.199368	65.00
66.00	06600	PHYSICAL THERAPY	1,025,093	2,888,698	3,913,791	0.308136	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	32,247	86,740	118,987	1.217713	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,021,963	4,790,026	7,811,989	0.196740	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	331,179	10,021,583	10,352,762	0.328891	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	15,159	594,211	609,370	1.333423	92.00
200.00		Subtotal (see instructions)	14,013,095	51,409,712	65,422,807		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	14,013,095	51,409,712	65,422,807		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151316

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

Worksheet C
Part I
Date/Time Prepared:
11/21/2012 3:01 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
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
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
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0.000000		71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	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: 151316

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

Worksheet C
Part I
Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Cost
				Total Costs	RCE Disallowance	Total Costs		
								3.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,899,556		4,899,556	0	0	30.00
43.00	04300	NURSERY	394,028		394,028	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,541,480		2,541,480	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	793,320		793,320	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,230,144		2,230,144	0	0	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	2,956,384		2,956,384	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	620,057	0	620,057	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,205,978	0	1,205,978	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	144,892	0	144,892	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0		0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,536,930		1,536,930	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,404,933		3,404,933	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	812,548		812,548	0	0	92.00
200.00		Subtotal (see instructions)	21,540,250	0	21,540,250	0	0	200.00
201.00		Less Observation Beds	812,548		812,548	0	0	201.00
202.00		Total (see instructions)	20,727,702	0	20,727,702	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151316

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

Worksheet C
Part I
Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,521,482		3,521,482		30.00
43.00	04300	NURSERY	527,408		527,408		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,664,626	7,024,108	8,688,734	0.292503	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	956,972	31,947	988,919	0.802209	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	791,944	13,083,224	13,875,168	0.160729	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,017,151	10,886,937	11,904,088	0.248350	60.00
65.00	06500	RESPIRATORY THERAPY	1,107,871	2,002,238	3,110,109	0.199368	65.00
66.00	06600	PHYSICAL THERAPY	1,025,093	2,888,698	3,913,791	0.308136	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	32,247	86,740	118,987	1.217713	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,021,963	4,790,026	7,811,989	0.196740	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	331,179	10,021,583	10,352,762	0.328891	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	15,159	594,211	609,370	1.333423	92.00
200.00		Subtotal (see instructions)	14,013,095	51,409,712	65,422,807		200.00
201.00		Less observation Beds					201.00
202.00		Total (see instructions)	14,013,095	51,409,712	65,422,807		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151316

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

Worksheet C
Part I
Date/Time Prepared:
11/21/2012 3:01 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
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
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
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0.000000		71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	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: 151316

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

Worksheet D
Part II
Date/Time Prepared:
11/21/2012 3:01 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	218,762	8,688,734	0.025178	451,970	11,380	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	49,909	988,919	0.050468	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	154,841	13,875,168	0.011160	380,987	4,252	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	97,455	11,904,088	0.008187	514,966	4,216	60.00
65.00	06500 RESPIRATORY THERAPY	33,789	3,110,109	0.010864	440,239	4,783	65.00
66.00	06600 PHYSICAL THERAPY	65,995	3,913,791	0.016862	289,809	4,887	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	10,893	118,987	0.091548	18,689	1,711	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
71.30	07101 IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0	0	71.30
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	61,009	7,811,989	0.007810	1,622,022	12,668	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	155,671	10,352,762	0.015037	25,594	385	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	609,370	0.000000	0	0	92.00
200.00	Total (lines 50-199)	848,324	61,373,917		3,744,276	44,282	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316

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

Worksheet D
Part IV
Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description	Title XVIII				Hospital	Cost	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	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: 151316

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

Worksheet D
Part IV
Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description	Title XVIII			Hospital		Cost		
	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges			
	6.00	7.00	8.00	9.00	10.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	8,688,734	0.000000	0.000000	451,970	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	988,919	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,875,168	0.000000	0.000000	380,987	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	11,904,088	0.000000	0.000000	514,966	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,110,109	0.000000	0.000000	440,239	65.00
66.00	06600	PHYSICAL THERAPY	0	3,913,791	0.000000	0.000000	289,809	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	118,987	0.000000	0.000000	18,689	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0.000000	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,811,989	0.000000	0.000000	1,622,022	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	10,352,762	0.000000	0.000000	25,594	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	609,370	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	61,373,917			3,744,276	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316

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

Worksheet D
Part IV
Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description			Title XVIII			Hospital	Cost	
			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	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: 151316

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

Worksheet D
Part IV
Date/Time Prepared:
11/21/2012 3:01 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0		71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	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: 151316

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

Worksheet D
Part V
Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Hospital	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
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.292503	0	1,873,964	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.802209	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.160729	0	3,793,574	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000	LABORATORY	0.248350	0	3,533,525	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.199368	0	549,065	0	65.00
66.00	06600	PHYSICAL THERAPY	0.308136	0	912,280	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.217713	0	15,098	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196740	0	2,374,741	5,288	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.328891	0	2,750,103	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.333423	0	294,500	0	92.00
200.00		Subtotal (see instructions)		0	16,096,850	5,288	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	16,096,850	5,288	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151316

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

Worksheet D
Part V
Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description		Costs			Hospital	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	548,140	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	609,737	0		54.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	877,551	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	109,466	0		65.00
66.00	06600 PHYSICAL THERAPY	0	281,106	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	18,385	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
71.30	07101 IMPL. DEV. CHARGED TO PATIENT	0	0	0		71.30
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	467,207	1,040		73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	904,484	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	392,693	0		92.00
200.00	Subtotal (see instructions)	0	4,208,769	1,040		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	4,208,769	1,040		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151316	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/21/2012 3:01 pm
	Component CCN: 152316		

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
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.292503	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.802209	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.160729	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000	LABORATORY	0.248350	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.199368	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.308136	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.217713	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196740	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.328891	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.333423	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: 151316

Period: From 07/01/2011

Worksheet D

Component CCN: 152316

To 06/30/2012

Part V

Date/Time Prepared: 11/21/2012 3:01 pm

Cost Center Description		Costs			Swing Beds - SNF	Cost
		PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151316	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1
		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)		4,042	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,262	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)		2,606	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		341	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)		341	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		49	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)		49	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,421	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)		341	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)		341	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)		4,899,556	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)		7,191	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)		7,191	25.00
26.00	Total swing-bed cost (see instructions)		859,128	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,040,428	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		5,503,907	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		5,503,907	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.734102	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)		2,112.01	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)		4,040,428	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)		1,238.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,760,093	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)		1,760,093	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151316

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

Worksheet D-1

Date/Time Prepared:
11/21/2012 3:01 pm

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)	
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	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)					848,695	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,608,788	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)					422,373	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					422,373	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					844,746	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)					656	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,238.64	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					812,548	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151316

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

Worksheet D-1

Date/Time Prepared:
11/21/2012 3:01 pm

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151316

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

Worksheet D-1

Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,042 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,262 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)			2,606 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			341 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)			341 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			49 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)			49 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			400 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			432 15.00
16.00	Nursery days (title V or XIX only)			242 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)			4,899,556 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)			847,235 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			4,052,321 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			5,503,907 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			5,503,907 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.736263 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)			2,112.01 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)			4,052,321 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)			1,242.28 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			496,912 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)			496,912 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151316

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

Worksheet D-1

Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description	Title XIX			Hospital		Program Cost (col. 3 x col. 4)	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Cost		
42.00 NURSERY (title V & XIX only)	394,028	432	912.10	4.00	242	220,728	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)						266,442	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						984,082	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)						656	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,242.28	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						814,936	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151316		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1 Date/Time Prepared: 11/21/2012 3:01 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION-BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151316

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

Worksheet D-3

Date/Time Prepared:
11/21/2012 3:01 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		1,221,048	30.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.292503	451,970	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.802209	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.160729	380,987	54.00
57.00	05700 CT SCAN	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000 LABORATORY	0.248350	514,966	60.00
65.00	06500 RESPIRATORY THERAPY	0.199368	440,239	65.00
66.00	06600 PHYSICAL THERAPY	0.308136	289,809	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	1.217713	18,689	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
71.30	07101 IMPL. DEV. CHARGED TO PATIENT	0.000000	0	71.30
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.196740	1,622,022	73.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.328891	25,594	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.333423	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		3,744,276	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		3,744,276	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151316

Period: From 07/01/2011

Worksheet D-3

Component CCN: 152316

To 06/30/2012

Date/Time Prepared: 11/21/2012 3:01 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		0		30.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.292503	5,942	1,738	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.802209	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.160729	15,419	2,478	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.248350	38,102	9,463	60.00
65.00	06500 RESPIRATORY THERAPY	0.199368	72,617	14,478	65.00
66.00	06600 PHYSICAL THERAPY	0.308136	631,960	194,730	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	1.217713	11,443	13,934	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
71.30	07101 IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	71.30
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.196740	369,211	72,639	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.328891	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.333423	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,144,694	309,460	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)		1,144,694		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151316	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 11/21/2012 3:01 pm
--	----------------------	---	--

Cost Center Description	Title XIX		Hospital		Cost
	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)		
	1.00	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY		1,283,009	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.292503	440,676	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.802209	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.160729	41,670	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.248350	155,953	60.00
65.00	06500	RESPIRATORY THERAPY	0.199368	79,537	65.00
66.00	06600	PHYSICAL THERAPY	0.308136	14,968	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.217713	2,115	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196740	330,405	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.328891	12,364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.333423	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,077,688	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		1,077,688	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151316	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/21/2012 3:01 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,209,809	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)		4,209,809	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)		4,251,907	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)		35,739	25.00
26.00	Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)		2,524,770	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)		1,691,398	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)		1,691,398	30.00
31.00	Primary payer payments		1,103	31.00
32.00	Subtotal (line 30 minus line 31)		1,690,295	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)		313,952	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		313,952	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		313,952	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		2,004,247	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)		2,004,247	40.00
41.00	Interim payments		1,795,310	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)		208,937	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: 151316	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/21/2012 3:01 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: 151316

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

Worksheet E-1
Part I
Date/Time Prepared:
11/21/2012 3:01 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						1.00
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		1,950,830		1,675,458		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	03/27/2012	167,773	03/27/2012	96,578		3.01
3.02		06/14/2012	34,780	06/14/2012	23,274		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)		202,553		119,852		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)		2,153,383		1,795,310		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		172,591		208,937		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		2,325,974		2,004,247		7.00
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151316
Component CCN: 15Z316

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

Worksheet E-1
Part I
Date/Time Prepared:
11/21/2012 3:01 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					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		1,002,711			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	03/27/2012	55,225			0	3.01
3.02		06/14/2012	17,578			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)		72,803			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)		1,075,514			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		83,722			0	6.01
6.02	SETTLEMENT TO PROGRAM		0			0	6.02
7.00	Total Medicare program liability (see instructions)		1,159,236			0	7.00
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151316
Component CCN: 152316

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

Worksheet E-2
Date/Time Prepared:
11/21/2012 3:01 pm

		Swing Beds - SNF		Cost	
		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)	853,193	0	1.00	2.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				
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)	312,555	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	682	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)	1,165,748	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	1,165,748	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)	1,165,748	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,512	0	13.00	
14.00	80% of Part B costs (line 12 x 80%)		0	14.00	
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,159,236	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)	1,159,236	0	19.00	
20.00	Interim payments	1,075,514	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)	83,722	0	22.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-III, section 115.2	0	0	23.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151316	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part V Date/Time Prepared: 11/21/2012 3:01 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		2,608,788	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)		2,608,788	4.00
5.00	Primary payer payments		10,630	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,624,246	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)		2,624,246	19.00
20.00	Deductibles (exclude professional component)		319,225	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		2,305,021	22.00
23.00	Coinsurance		4,624	23.00
24.00	Subtotal (line 22 minus line 23)		2,300,397	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		25,577	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		25,577	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		25,577	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,325,974	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)		2,325,974	30.00
31.00	Interim payments		2,153,383	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)		172,591	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: 151316	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part VII Date/Time Prepared: 11/21/2012 3:01 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	984,082	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)	984,082	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)	984,082	7.00
COMPUTATION OF LESSER OF COST OR CHARGES			
Reasonable Charges			
8.00	Routine service charges	1,283,009	8.00
9.00	Ancillary service charges	1,077,688	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)	2,360,697	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)	2,360,697	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,376,615	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)	984,082	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.	984,082	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)	984,082	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)	984,082	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	37.00
38.00	Subtotal (line 36 ± line 37)	984,082	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)	984,082	40.00
41.00	Interim payments	984,082	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: 151316

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

Worksheet G

Date/Time Prepared:
11/21/2012 3:01 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	1,490,814	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,103,153	0	0	0	4.00
5.00	Other receivable	279,407	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,194,913	0	0	0	6.00
7.00	Inventory	381,280	0	0	0	7.00
8.00	Prepaid expenses	36,178	0	0	0	8.00
9.00	Other current assets	1,156,544	0	0	0	9.00
10.00	Due from other funds	-44,248	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,208,215	0	0	0	11.00
FIXED ASSETS						
12.00	Land	160,146	0	0	0	12.00
13.00	Land improvements	66,241	0	0	0	13.00
14.00	Accumulated depreciation	-23,346	0	0	0	14.00
15.00	Buildings	1,885,109	0	0	0	15.00
16.00	Accumulated depreciation	-614,588	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	758,364	0	0	0	19.00
20.00	Accumulated depreciation	-414,807	0	0	0	20.00
21.00	Automobiles and trucks	25,700	0	0	0	21.00
22.00	Accumulated depreciation	-18,204	0	0	0	22.00
23.00	Major movable equipment	6,036,617	0	0	0	23.00
24.00	Accumulated depreciation	-4,869,135	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)	2,992,097	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	30,624,197	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	14,098	44,248	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	30,638,295	44,248	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	38,838,607	44,248	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,931,516	0	0	0	37.00
38.00	Salaries, wages, and fees payable	898,041	0	0	0	38.00
39.00	Payroll taxes payable	82,608	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,240,172	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,152,337	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	849,385	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	849,385	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,001,722	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	31,836,885				52.00
53.00	Specific purpose fund		44,248			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	31,836,885	44,248	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	38,838,607	44,248	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151316

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

Worksheet G-1

Date/Time Prepared:
11/21/2012 3:01 pm

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
1.00 Fund balances at beginning of period		30,210,464		-3,260	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		1,855,394			2.00
3.00 Total (sum of line 1 and line 2)		32,065,858		-3,260	3.00
4.00 TRANSFERS FROM AFFILIATES	34,905		0		4.00
5.00 RESTRICTED CONTRIB USED FOR PROPERTY	31,061		0		5.00
6.00 DEFERRED PENSION COST	271,165		0		6.00
7.00 GRANTS	0		53,387		7.00
8.00 OTHER	0		36,083		8.00
9.00	0		0		9.00
10.00 Total additions (sum of line 4-9)		337,131		89,470	10.00
11.00 Subtotal (line 3 plus line 10)		32,402,989		86,210	11.00
12.00 OTHER ADJUSTMENTS	36,085		0		12.00
13.00 OTHER PENSION RELATED NET ASSET ADJ	530,019		0		13.00
14.00 NET ASSETS RELEASED FROM RESTRICTION	0		41,962		14.00
15.00	0		0		15.00
16.00	0		0		16.00
17.00	0		0		17.00
18.00 Total deductions (sum of lines 12-17)		566,104		41,962	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		31,836,885		44,248	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151316

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

Worksheet G-1

Date/Time Prepared:
11/21/2012 3:01 pm

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00						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
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: 151316

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/21/2012 3:01 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	5,503,907		5,503,907	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)	5,503,907		5,503,907	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)	5,503,907		5,503,907	17.00
18.00	Ancillary services	8,934,382	41,582,712	50,517,094	18.00
19.00	Outpatient services	320,254	9,935,526	10,255,780	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	272,331	272,331	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	14,758,543	51,790,569	66,549,112	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		23,802,167		29.00
30.00	BAD DEBTS	3,644,544			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)		3,644,544		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)		27,446,711		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151316

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

Worksheet G-3

Date/Time Prepared:
11/21/2012 3:01 pm

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	66,549,112	1.00
2.00	Less contractual allowances and discounts on patients' accounts	37,539,864	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,009,248	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	27,446,711	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,562,537	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,505,148	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	116,001	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	19,637	17.00
18.00	Revenue from sale of medical records and abstracts	7,294	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	174,792	22.00
23.00	Governmental appropriations	0	23.00
24.00	NET ASSETS RELEASED FROM RESTRICTION	10,901	24.00
24.01	MISC INCOME	8,646	24.01
24.02	FOUNDATION	7,533	24.02
24.03	GRANTS	69,887	24.03
24.04	NON-CASH FUNDED PENSION CURTAILMENT	519,430	24.04
25.00	Total other income (sum of lines 6-24)	2,439,269	25.00
26.00	Total (line 5 plus line 25)	4,001,806	26.00
27.00	UNREALIZED LOSSES	2,146,412	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2,146,412	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,855,394	29.00